

BURNOUT, EMPATHY, AND SELF-CARE AMONG
MENTAL HEALTH COUNSELORS

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BURNOUT, EMPATHY, AND SELF-CARE AMONG
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To the constants in my life, I thank you. I have arrived.

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Abstract:

The implications of burnout for those who engage in human service work continue to be of significant interest. Burnout prevalence, specifically in the form of emotional exhaustion among mental health counselors, has been of particular interests due to the unique interpersonal nature of their work and the exposure to unique stressors for which many counselors are not equipped with the necessary resources or strategies to effectively cope. Empathy, a vital component of counseling, has been shown to serve as both a protective factor and risk factor to the development of burnout. A growing body of research has highlighted the role of self-care in mitigating burnout symptoms particularly for those in the mental health field. Thus, the current study examined the relationship between burnout, empathy, and self-care among 111 mental health counselors from various mental health agencies in the United States. The main goals of the study were to examine the bi-variate and liner relationships between empathy and burnout and to determine whether self-care significantly moderated the relationship between the empathy variables and burnout. The results of the study provided minimal support for the stated hypotheses. Personal distress was the only empathy variable that was significantly correlated with burnout, though it did not significantly predict burnout. Self-care was shown to significantly predict burnout scores above and beyond each empathy variable. Additionally, hierarchical linear regression analyses only revealed a significant moderating effect of self-compassion on the relationship between empathic concern and burnout, though further examination of the interaction revealed that none of the simple slopes were significant. Implications and future areas for research are discussed.

Keywords: burnout, empathy, self-care, mental health, counselors

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CHAPTER I

Introduction

Job stress continues to be a common and costly problem that affects workers in American. According to the National Institute for Occupational Safety and Health (NIOSH) previous survey data found that over 40% of American workers report that their job is very or extremely stressful (NIOSH, 1999). Also, according to NIOSH, the number of workers that reported being ‘burdened out or stressed by their work’ and ‘feeling quite a bit or extremely stressed out at work’ stands at 26% and 29%, respectively. More recent data parallels these findings, concluding that 41% of employed adults in the United States report feeling stressed at work (American Psychological Association, 2015). Aside from the prevalence, job organizations are also impacted by issues of job stress. Due to costs accrued from employee absenteeism, reduced productivity, and health care, it has been estimated that employers pay between \$200 to 350 billion in the United States, \$64.8 to \$66.1 billion in the United Kingdom, and \$232 billion in Japan (Mire, 2007). Despite these startling figures, a large portion of workers do not feel that they have adequate resources to manage work stress (NIOSH, 1999). Therefore, occupational stress appears to have serious consequences for employees and organizations.

Research has focused on work-related stressors on individuals across many occupations. NIOSH defines job stress as the “the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources or needs of the worker” (p.6), and acknowledges both working conditions and personal factors as involved in this process, though the former being most influential. Some stressors, for example, include low financial compensation, excessive workload, staff shortages, mundane work duties, poor social support, lack of control, ambiguous work duties, and so forth (Nixon, Mazzola, Bauer, Krueger & Spector, 2011). Workplace stress has been linked to poor mental well-being including depression and anxiety (Gerber, Jonsdottir, Lindwall, & Ahlborg, 2014; Landsbergis, 1988; Pugliesi, 1999); onset and progression of physical maladies including backache, headache, eyestrain, sleep disturbances, fatigue, and gastrointestinal problems (Nixon et al., 2011); and poor work outcomes on the part of the individual which adversely affects organization (Melchior et al., 2007; NIOSH, 1999). Although all employees are susceptible to developing stress, mental health counselors seem to be at particular risk.

The emotional component of interpersonal interactions is prevalent in human services, including mental health counselors, and has garnered much empirical review. It is seen as a requirement for human service workers, especially mental health counselors, to adequately display appropriate emotions towards client, even when appropriate behaviors from clients are not forthcoming or reciprocated (Ogunsja-Bulik, 2005; Zapf, 2002). Hochschild (1983) notes that emotional labor, defined as the performance of various forms of emotional management, is subject to occupational control, which may account for the negative psychological consequences for workers (Mann, 2010; Pugliesi, 1999). Today,

given the rise of managed healthcare, mental health counselors are inundated with guidelines and procedures aimed at facilitating rapid and long-lasting clinical outcomes, all while increasing demands in the form of heightened documentation, caseloads, financial constrictions and ethical concerns (Rupert & Morgan, 2005). Increased workload, inappropriate referrals, role ambiguity, working conditions and lack of resources, minimal supervisory support, job insecurity and safety issues have all been identified as stressors central to the work of those in the mental health profession (Edwards, Burnard, Coyle, Fothergill & Hannigan, 2000; Mogammad Mosadeghrad, 2014; Wade, Cooley & Savicki, 1986). As a result, these demands have been shown to lead to reductions in areas of interpersonal, e.g., warmth, sensitivity, tolerance for others, and cognitive/motivational, e.g., composure, concentration, adaptability, performance (Motowidlo, Packard & Manning, 1986). Given that mental health counselors report many personal problems, such as depression, anxiety, somatic complaints, suicidal ideation, and so forth (Gilroy, Carroll & Murra, 2002; Gilroy, Carrol & Murra, 2015; Mahoney, 1997; Pope & Tabachnick, 1994), these symptoms can become exacerbated leading to more severe forms of stress including compassion fatigue (Figley, 1993), vicarious traumatization (McCann & Pearlman, 1990), and burnout (Maslach & Jackson, 1981).

Prevalence rates of burnout in mental health professionals are strikingly high (Ackerly, Burnell, Holder, & Kurdek, 1988; Farber & Heifetz, 1972; Rupert & Morgan, 2005). The construct of burnout has generally been categorized as a syndrome consisting of an emotional/physical exhaustion, depersonalization, and reduced sense of personal accomplishment (Freudenberger, 1974; Jackson, Schwab & Schuler, 1986; Maslach & Pines, 1977; Maslach, Schaufeli & Leiter, 2001; Miller, 1995; Pines & Aronson, 1981). Maslach

and colleagues (2001) define burnout as “a prolonged response to chronic emotional and interpersonal stressors on the job, causing exhaustion, cynicism and inefficacy on the job” (p. 397). Physical manifestations of burnout include sleep disturbances, lack of energy for work, physiological arousal, and gastrointestinal problems (Jackson & Maslach, 1982; Melamed et al., 2006; Pines & Aranson, 1981). Emotional indicators of burnout have been commonly cited as apathy, anxiety, hopelessness, irritability, and criticism of self/others (Radziewicz, 2001). Though contemporary prevalence rates of burnout are scant in literature, recent studies note that burnout continues to be a significant issue for mental health service providers, thus warranting further exploration (Rupert & Morgan, 2005).

Many counselors come into the field with the expectation that their contributions will invariably lead to the amelioration of clients’ concerns, failing to grasp the lack of control that they actually have over the outcomes of clients. These failed expectations can then lead counselors to detach themselves from their job duties and experience a reduced sense of competence and accomplishment, which are indicative of burnout (Duetsch, 1984; Freudenberger & North, 1985; Maslach, 2001). Empirical studies have noted other potential antecedents of burnout that include personality characteristics (Alarcon, Eschleman & Bowling, 2009; Bakker, Van Der Zee, Lewig & Dollard, 2006; Zellars, Perrewe, & Hochwarter, 2000), demographic variables (Newell & MacNeil, 2011; Ackerly et al., 1988), and work/organizational characteristics (Gillespie & Numerof, 1991; Leiter & Maslach, 1988; Maslach & Pines, 1977; Rzesutek & Schier, 2014). Though these stressors have been noted to be deleterious to mental health counselors’ health, the burnout syndrome can limit counselors from providing adequate services to their clients.

There is a lack of general consensus on definition of the construct of empathy (Eisenbergh & Strayer, 1991). For the purposes of this study, empathy can be described as the reactions of an individual in relation to observing another (Davis, 1983). These reactions can take the form of cognitive, affective and behavioral/physiological responses (Barrett-Lennard, 1981; Batson, Eklund, Chermok, Hoyt & Ortiz, 2007; Bucheheimer, 1963; Davis, 1983; Eisenbergh & Strayer, 1991; Elliot and colleagues, 2011; Elliot, Watson, Goldman & Greenberg, 2003; Gallese, 2001; Gallese, 2003; Hoffman, 1984; Rogers, 1957; Schroeder, Dovidio, Sibicky, Matthews & Allen, 1988; Völlm et al., 2006). Davis (1983) delineated ways that people relate towards one another into four categories. Perspective Taking (PT) is the cognitive ability to take the perspective of another individual (Gallese, 2001). In the therapy setting, the therapist is able to attune to and psychologically reenact the experience of the client. Empathic Concern (EC) is experiencing feelings of concern for the other's misfortune or plight (Batson, Eklund, Chermok, Hoyt & Ortiz, 2007). Personal Distress (PD) involves observer experience of discomfort, such as anxiety and sadness, in reaction to the experience of others (Zahn-Waxler & Radke-Yarrow, 1990). Finally, Fantasy (FS) is indicative of the transposition of one's *self* into the thoughts and feelings of fictitious characters in books, movies and plays (Davis, 1983).

Empirical studies have demonstrated that the therapeutic relationship is the most essential component of therapy (Karver, Handelsman, Fields & Buckmann, 2006; Norcross & Wampold, 2011; Silverman, 2001) even across treatment modalities (Arnow et al., 2013). These findings are in line with Roger's (1957) assertion that the relationship is "necessary and sufficient", though some researchers may disagree (Strupp, 1978). Nevertheless, empathy in particular has been regarded as the most important aspect to the therapeutic relationship

(Norcross & Wampold, 2011; Rogers, 1957). Empirical evidence has revealed that empathy leads to greater interpersonal exploration and client self-disclosure (Kurtz & Grummon, 1972; Traux & Carkhuff, 1967; Truax & Carkhuff, 1965), clients feelings of safety (Greenberg, Watson, Elliot & Hobart, 2001), therapy longevity (Kasarabada, Hser, Boles & Huang, 2002), and overall positive ratings of counselor and counseling (Grigg & Goodstein, 1957). Additionally, meta-analysis studies on therapy outcomes have generated robust support for the utility of empathy in counseling (Elliot, Bohart, Watson, & Greenber, 2011; Greenberg, Watson, Elliot & Bohart, 2001; Kurtz & Grummon, 1972).

Research studies have produced mixed findings regarding empathy and its utility in the counseling setting, specifically as it relates to its impact on the client and counselor. While some researchers (Miller et al., 1995) maintain that empathy allows for effective communication between the counselor and client, others have noted detrimental effects (Miller, Stiff & Elis, 1988). For example, Black and Weinreich (2003) suggested that empathic responding, particularly affective (versus cognitive or behavioral) responding, can exacerbate symptoms that lead to compassion fatigue and burnout. Emotionally fusing with clients can also have negative consequences (Williams, 1989; Zahn-Waxler & Radke-Yarrow, 1990), especially if they do not have sufficient coping strategies (Maslach, 1982). Day and Chambers (1991) found that personal distress was positively related to emotional exhaustion, depersonalization and reduced sense of personal accomplishment. Increased personal distress has also been linked to diminished therapeutic effectiveness in therapists, which can contribute to diminished personal accomplishment (Hall, Davis & Connelly, 2000). Gross (1994) observed empathetic concern to be predictive of depersonalization, i.e., feelings of callousness towards clients, though other studies have noted this form of

detachment from clients to be an adaptive coping strategy when dealing with intense emotions and job demands (Lief & Fox, 1963; Sonnentag, Binnewies & Kinstanz, 2010). These disparate findings regarding empathy and burnout warrant further review.

Impairment can take many forms in helping professionals, including distress and burnout. As such, in the last few decades, professional communities have broadened their view of self-care to that of attending to and caring for the self. The ACA Code of Ethics provides a more thorough description of impairment by stating that “counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired,” (ACA, 2014; Section C.2.g., p.9). To alleviate forms of impairment, counselors are encouraged to engage in self-care practices which can be defined as the maintenance and promotion of emotional, physical, mental, spiritual and overall wellbeing (ACA, 2014; Section C, p.8).

Self-care can take many forms (Carroll, Gilroy & Murra, 2013; O’Halloran & O’Halloran, 2001) and has been related to positive health outcomes (Briggs & Shoffner, 2006; Kirby, Coleman & Daley, 2004; Moberg, 2008; Shapiro, Brown & Biegel, 2007; Sharkey & Sharples; 2003). Despite the reported rates of self-care practices amongst mental health counselors (Bober & Regehr, 2006; Mahoney, 1997), there are still various barriers that contribute to low utilization rates (Carroll, Gilroy & Murra, 2003; Gilroy, Carroll & Murra, 2015).

Purpose of the Study

Very limited data exists in the research literature concerning the relationships between burnout, empathy and self-care practices among mental health counselors. Although

considerable research has examined the relationships between empathy and burnout, research is still mixed in determining the nature of the relationships between these variables (Day & Chambers, 1991; Miller et al., 1995; Skorupa & Afresti, 1993). In line with the aims of this study, emotional exhaustion was the only component of burnout used in examining the main research hypotheses, and for several reasons. First, emotional exhaustion has been categorized as the most stable and core component of burnout (Demerouti, Bakker, Nachreiner & Schaufeli, 2001; Gaines & Jermier, 1983; Lee & Ashforth, 1993; Maslach, 1982). Additionally, burnout has been conceptualized as a syndrome beginning with emotional exhaustion (Leiter & Maslach, 1988; Maslach, 1982). Thus, attending to this facet of burnout is likely to help with intervening earlier in this process so as to reduce the severity of this syndrome. Moreover, emotional exhaustion is suggested to explicitly tap into the chronic affective components of work experiences, specifically in the work of mental health counselors (Gaines & Jermier, 1983). Further, based on this researcher's knowledge, examining whether reported self-care practices can serve as a "buffering effect" for empathy levels of mental health counselors and protect against burnout appears to be a novel endeavor. Thus, this research is exploratory in nature. Therefore, purposes of this study were to: 1) Explore the bivariate and linear relationships between empathy, self-care and emotional exhaustion, and 2) to assess whether self-care serves as a potential moderator between empathy and emotional exhaustion.

Research Questions

The research questions explored in this study are as follows:

1. Is there a significant association between empathic concern and emotional exhaustion among mental health counselors? And does self-care moderate the relationship between empathic concern and emotional exhaustion among mental health counselors?

Hypothesis 1a: There will be a significant relationship between the empathic concern and burnout among mental health counselors.

Hypothesis 1b: Self-care will moderate the relationship between empathic concern and emotional exhaustion among mental health counselors.

2. Is there a significant association between perspective taking and emotional exhaustion among mental health counselors? And does self-care moderate the relationship between empathic concern and emotional exhaustion among mental health counselors?

Hypothesis 2a: There will be a significant relationship between the perspective taking and burnout among mental health counselors.

Hypothesis 2b: Self-care will moderate the relationship between perspective taking and emotional exhaustion among mental health counselors.

3. Is there a significant association between personal distress and emotional exhaustion among mental health counselors? And does self-care moderate the relationship between personal distress and emotional exhaustion among mental health counselors?

Hypothesis 3a: There will be a significant relationship between the personal distress and burnout among mental health counselors.

Hypothesis 3b: Self-care will moderate the relationship between personal distress and emotional exhaustion among mental health counselors.

4. Is there a significant association between self-care and emotional exhaustion among mental health counselors?

Hypothesis 4: There will be a significant, positive relationship between self-care and burnout among mental health counselors.

CHAPTER II

Review of Literature

The majority of this appendix will focus on a review of literature on the primary variables of the study, namely burnout, empathy and self-care. This review will begin with a discussion on definition and theoretical issues underlying burnout, followed by relevant literature. The chapter will follow a similar fashion with empathy and self-care, respectively.

Burnout

Definition and history of burnout. The term “burnout” has been used interchangeably with other conditions (Collins & Long, 2003), such compassion fatigue (Figley, 1993), vicarious traumatization (McCann & Pearlman, 1990) and secondary traumatic stress (Figley, 1995). Despite their similarities in symptomology, burnout has been shown to be a distinct construct (Rosenberg & Pace, 2006) with implications that go above and beyond its counterparts. According to Maslach et al. (1996), burnout differs from occupational stress based on its specificity to work that requires intense labor. This is different than occupational stress, which is generally depicted as manifesting due to an

imbalance between occupational demands and available physical and psychological resources (NIOSH, 1999).

Freudenberger (1974) was the first to coin the term “burnout” in reference to the effects of prolonged drug use. Based on his clinical research of human service workers, Fredenberger observed that individuals, once encompassing seemingly positive, adaptive states, such as enthusiasm and optimism, began to exhibit less desirable states, like those of anger and despair. He saw burnout as a state of depletion, wherein individuals’, while attempting to achieve unrealistic expectations, effectively exhaust both their physical and cognitive resources (Miller, 1995). Thus, burnout appears to manifest when professionals are no longer able to maintain the care and commitment to effective care of clients that they once brought to the job (Maslach & Pines, 1977).

Shortly thereafter, Maslach began to apply the concept of burnout to her research that focused on compensatory strategies used by a wide-range of human service workers who experience emotional arousal on the job (Maslach, Schaufeli & Leiter, 2001). Through these observations, Maslach sought to define burnout as a syndrome of physical and emotional exhaustion, cynicism and a low sense of one’s accomplishments as a result of engaging in “people work” (Maslach & Jackson, 1981). Similarly, Pines and Aranson (1988) suggested burnout to comprise physical, emotional, and mental exhaustion as a result to prolonged interactions with emotionally demanding people and situations. Burnout was later was refined into three dimensions, including emotional exhaustion, depersonalization and reduced personal accomplishment, to reflect the components of the Maslach Burnout Inventory (MBI- Maslach & Jackson, 1981).

Though differing from other definitions, many support the idea that burnout comprises the three distinct features of emotional exhaustion, depersonalization and feelings of low personal accomplishment (Jackson, Schwab & Schuler, 1986; Maslach, Schaufeli & Leiter, 2001; Pines & Aronson, 1981). For the purposes of this research, the definition of burnout that will be used is taken from Maslach and colleagues (2001) who defined burnout as “a prolonged response to chronic emotional and interpersonal stressors on the job, causing exhaustion, cynicism and inefficacy on the job” (p. 397).

Models of burnout. Myriad models of burnout have surfaced over the years to describe the process of burnout. Despite decades since its inception, the multidimensional theory of burnout (Maslach & Jackson, 1981; Maslach, 1998) is hailed as the most influential and predominant theoretical framework to understanding the burnout phenomenon (Maslach, Schaufeli & Leiter, 2001). Based on this conceptualization, burnout is considered to be a tri-dimensional process consisting of three central elements: emotional exhaustion, depersonalization and reduced personal accomplishment. Emotional exhaustion refers to the degree to which an individual feels overextended and emotionally exhausted by his or her work. Depersonalization (also referred to as cynicism and disengagement in the literature) refers to the degree to which an individual becomes unresponsive and impersonal towards the recipient of services. Personal accomplishment reflects the individual’s sense of competence, efficacy and accomplishment at his or her work. Accordingly, a high degree of emotional exhaustion and depersonalization, and low degree of personal accomplishment is indicative of a high degree of burnout.

Other theories of burnout appear to be more limited due to a limited number of dimensions. Freudenberger’s (1975) theory of burnout focused on the fatigue and

frustration of the professional that resulted from unfulfilled expectations. Conversely, Pines and Aronson's theory (1988) described the development of burnout as occurring from the emotional, physical, and psychological exhaustion that is brought about by engaging with clients. These theories share commonalities in that they embrace an emotional dimension to burnout; however, their brevity in explaining the process of burnout renders them incapable of standing on their own. Still, their inclusion in the study adds support for the use of Maslach's theory of burnout in this study.

Demerouti, Bakker, Nachreiner and Schaufeli (2001) proposed a model for burnout based on working conditions that fall under two broad categories: *job demands* and *job resources*. According to the job demands-resources model (JD-R), job demands, which refers to the physical, social, or organizational aspects of the job that require sustained physical or mental effort, depletes one's psychological and physiological faculties; job resources, on the other hand, are the physical, psychological, social, or organizational aspects of the job that help to (a) achieve work goals, (b) reduce job demands and the associated psychological and physiological costs, and (c) stimulate personal growth and development. According to this model, burnout occurs when there are consistent job demands (e.g., work-load) that that overtax the individual, thus leading to emotional exhaustion, and when lack of resources are available which leads to withdrawal behavior and subsequent disengagement. Findings from this study supported the model in that job demands are primarily related to the exhaustion component of burnout whereas a lack of job resources is related to disengagement.

Interpersonal relationships have been shown to have an impact on burnout as well. Edelwich and Brosky (1980) contend that burnout does not occur in isolation but

can be exacerbated by social relationships. This belief is supported by Bakker, Demerouti and Schaufeli's (2003) *Socially Induced Burnout Model*. According to Bakker and colleagues (2003) burnout (i.e., emotional exhaustion, cynicism, professional efficacy) can be socially induced. The study was comprised of 490 employees from a large banking and insurance company. Results revealed a direct relationship between individual and team burnout (i.e., mean score of group burnout, excluding comparison's burnout score). However, the model did not hold up for the *cynicism* dimension of burnout. The authors hypothesized that workers who are cynical keep distance from both their work and colleagues which may diminish the social effect of burnout (Bakker, Demerouti & Schaufeli, 2003).

Some of the more prominent models of burnout point to causal relationships between the various dimensions. Leiter and Maslach (1988) proposed a model whereby burnout progresses from emotional exhaustion, to depersonalization, finally leading to a lack of personal accomplishment (Leiter & Maslach, 1988). Golembiewski, Boudreau, Munzenrider and Luo (1996), on the other hand, depict a progression from depersonalizing as a dysfunctional means of coping to stress, followed by lack of personal accomplishment because of hampered performance, and eventual emotional exhaustion. Empirical support has been found for the Leiter and Maslach model. Lee and Ashforth (1993), for example, in a longitudinal study of consisting of 223 human service supervisors and managers found support for the Leiter and Maslach model. Using structural equation modeling, emotional exhaustion mediated work strain (e.g., autonomy, social support, and role stress) and the two other dimensions of burnout. More recently, Taris, Le Blanc, Schaufeli, and Schreurs (2005), in their review of studies that

provided causal support for three most influential process models (Leiter & Maslach, 1988; Lee & Ashforth's, 1993; Golembiewski, Bourdreau, Munzenrider & Luo, 1996), found much of these claims to be unwarranted. The main discrepancy that arose was the use of a cross-sectional design without any comparison.

In sum, many models of burnout have been created proposing various sources that aid in the development of this syndrome. Moreover, empirical evidence has established a strong relationship between the various dimensions of burnout, though the sequence in which each dimension is still debated. Still, the burnout syndrome can have severe consequences on individuals in the workplace and those who deal with people, specifically.

Symptoms and causes of burnout. Burnout has been linked to several clinical syndromes and physical health, including depression, anxiety, sleep disturbances, tension, and irritability (Gilroy, Carroll & Murra, 2002; Maslach, Schaufeli & Leiter, 2001; Jackson & Maslach, 1982). Melemed et al. (1999), in their study of 111 full-time employees of a large heavy machinery workshop, found that workers who exhibited chronic levels of burnout experienced increased somatic arousal, such as sleep disturbances, and physiological hyperarousal in the form of elevated cortisol levels, which have been attributed to risk of more severe physical illnesses, including cardiovascular disease (Manenschijn et al., 2013). Jackson and Maslach (1982) reported similar findings in their study on burnout among police officer. More specifically, they found emotional exhaustion to be related to disrupted sleep patterns in the sample. Further, based on self-reports of police officers' wives, Jackson and Maslach found that officers who scored higher on the emotional exhaustion portion of the burnout measure

were more likely to present home upset or angry, tense and anxious, and in a complaining mood.

Burke and Greenglass (1993) explored various antecedents of burnout. In this longitudinal study that consisted of 833 school educators, researchers used a model consisting of four variables cited in previous studies, including individual demographic and situational variables (e.g., education), work stressors (e.g., workload), role conflict (e.g., giving priority to family versus giving priority to yourself), and social support (e.g., immediate supervisors). Multiple hierarchical regressions were used, setting the three burnout scales (emotional exhaustion, depersonalization, personal accomplishment) as the dependent variables and the individual demographic and situational characteristics as control variables. Results revealed similar patterns on the burnout subscales and total scores when the predictor variables were regressed on them. More importantly, they found that work stressors significantly contributed significant increments in explained variance. Specifically, lack of stimulation and minimal interpersonal contacts were consistently predictive of burnout among educators in the sample, thus pointing to the unique role of work stress in worker distress.

In another study, Maslach and Florian (1988) conducted an exploratory study of burnout and subsequent outcomes of 38 rehabilitation counselors. Results from the study concluded that emotional exhaustion was higher in respondents who felt they had: no control over their work, larger caseloads, difficulty in implementing agency policy, and had less discretionary time outside of required tasks.

Emotional exhaustion has been commonly cited as the most significant component of burnout (Maslach & Jackson, 1984). This has been supported in various research findings that show that the effects of burnout superseding those of its counterparts, depersonalization and personal accomplishment. Because of these strong findings, some may recognize emotional exhaustion as the most vital symptoms of work-stress, however this should be met with caution. Problems related to small sample sizes and inadequate measures of may contribute to the disparate findings for the depersonalization and personal accomplishment components of burnout. Additionally, Maslach and Florian (1988) noted “the nature of the job ...with its client-oriented emphasis ...puts more of a demand on the emotional resources of counselors than it does on their interpersonal attitudes or sense of worth.” (p.91). This noticeable effect on workers across various occupations invariably leads researchers to develop and test hypotheses linking emotional exhaustion to various antecedents and consequences. Thus it is imperative for researchers to refrain from viewing burnout in a singular focus, and instead continuously develop models that speak to, what has been illustrated in past studies (Maslach & Jackson, 1984), the multidimensional aspect of this phenomenon (Maslach & Florian, 1988).

Burnout in mental health counselors. Based on the many demands and stressors affecting mental health counselors, it is reasonable to assume that they may be at increased risk for developing burnout, or related symptomology. In national sample of Gestalt and Cognitive Behavioral therapists in Poland, the most frequently cited burnout symptoms by respondents were being “tired of work,” “loss of commitment,” and “lack of energy for work” (Rzeszutek & Schier, p.577). As was noted in other health care

professions, burnout is prevalent in mental health workers, especially due to the emotional labor that is indicative of therapeutic work (Mann, 2004).

Early research on burnout rates within mental health counselors revealed a striking number, in that over a third of doctoral-level psychologist reported high levels of burnout (Ackerly, Burnell, Holder, & Kurdek, 1988). Another study by Farber and Heifetz (1972) found significant levels of burnout in 71% of therapist and 43% of psychiatrists surveyed. More recent data on burnout prevalence has found similar trends. Rupert and Morgan (2005), for example, sampled 571 clinical psychologists in the United States. Researchers noticed that 41% of psychologists experienced high levels of burnout symptoms, 26% fell within an average range, and only 29% fell in the low range. This was in contrast to the scores on the other dimensions of burnout wherein the percentage of respondents who fell in the moderate and low ranges was 53.4% and 90%, respectively.

The mindset that novice counselors bring to the field may be one of the very causes that make them more prone to suffering the deleterious effects of stressors inherent in mental health work. Freudenberger and North (1985), for example, cited the unreasonable expectations that many counselors harbor. For instance, Deutsch (1984) reported on the stress associated with therapists' irrational beliefs. Respondents rated the beliefs "I should always work at my peak level and enthusiasm and competence" and "I should be able to handle any client emergency that arises" as most stressful (p.839). Accordingly, these unrealistic beliefs interact with other factors that threaten healthy functioning in the counselor.

Personal factors. Bakker, Van Der Zee, Lewig and Dollard (2006) conducted a study exploring the relationship between the big five personality traits. The sample consisted of 80 Dutch volunteer counselors. The researchers conducted a series of hierarchical regressions with wherein the personality factors were predictors and subscales of the MBI. Results indicated that neuroticism ($B = .36$) significantly predicted emotional exhaustion; Neuroticism ($B = .32$), extraversion ($B = -.23$) and autonomy ($B = -.22$) significantly predicted depersonalization; and, extraversion ($B = .41$) and neuroticism ($B = -.26$) significantly predicted personal accomplishment. A similar study found that in a sample of health care staff, personality factors contributed unique variance to burnout above that of job-related stressors (Zellars, Perrewe, & Hochwarter, 2000). Meta-analysis research also lends support for the unique contribution of personality factors to overall burnout and related dimensions (Alarcon, Eschleman & Bowling, 2009).

Demographics factors. Research on racial and gender differences in burnout prevalence has been noted. Nonminority mental health workers have been shown to exhibit higher levels of emotional exhaustion as compared to their non-minority counterparts (Newell & MacNeil, 2011). Significant differences in personal accomplishment between people of different races/ethnicities have been documented (Rosenberg & Pace, 2006). Research on gender differences in burnout prevalence is mixed. While some studies report no gender differences (Ackerly et al., 1988), others have noted cited burnout rates to be greater for females (Maslach & Jackson, 1985). More specifically, studies have shown symptoms of burnout, particularly emotional exhaustion, to be greater for females (Newell & MacNeil, 2011), while personal depersonalization to be higher for males (Rosenberg and Pace, 2006). A study in Norway (Innstrand,

Langballe, Falkum & Aasland, 2011) examining burnout among various occupations produced mixed findings. While women exhibited greater levels of emotional exhaustion than males, there were no significant differences between males and females on the depersonalization dimension of burnout. Despite these findings, many researchers have cautioned against viewing burnout as a singular dimension. Purvanova and Muros (2007) in their meta-analysis examining research on gender differences and burnout found that women are more likely to be emotionally exhausted, whilst men are more likely to be emotionally exhausted. Additionally, as it relates to the commonly held belief that women are more likely to exhibit burnout, Purvanova and Muros stated that “the danger associated with this trend is that it helps perpetuate the myths that women are more ‘burnt-out’ than men, and that men are more resilient to stress than women.”(p. 177).

Organizational factors. Work characteristics, more so than personality and demographic variables (Raquepaw & Miller, 1989; Zellars, Perrewe, & Hichwarter, 2000), have been linked to burnout symptomology. Person to person interactions are a prominent feature of the work of mental health counselors, thus is why burnout has been shown to correlate with interpersonal functions, such as dealing with challenging clients, caseloads and direct client services, and organizational and peer support (Leiter & Maslach, 1988). Deutsch (1984) found that client behaviors significantly impacted therapists stress levels. In a sample of 264 master’s and doctoral level therapists, respondents categorized the following client behaviors as either moderately or highly stressful: clients’ suicidal statements (61%), inability to help an acutely distressed client (59%), client expression of anger towards therapist (58%), lack of observable progress

with client (50%), severely depressed client (52%), and apparent apathy or lack of motivation in client (51%). Empirical evidence has consistently shown significant relationships between burnout symptoms and quality of client contact. Specifically, therapists with higher levels of personal accomplishment report less negative client behaviors (Rupert & Morgan, 2005); though client characteristics are not always predictive burnout symptomology (Gillespie & Numerof, 1991; Puig, Yoon, Callueng, An & Lee, 2014).

Social support from supervisors and peers has too been shown to contribute significantly to worker functioning, and its impacts can be two fold. Supportive work place relationships have been shown to significantly decrease levels of burnout (Maslach & Pines, 1977; Rzeszutek & Schier, 2014). Further, positive supervisory experiences, specifically perceived adequacy of feedback (Gillespie & Numerof, 1991), has been linked to increased feelings of job satisfaction and personal accomplishment. Conversely, unpleasant supervisory contact has been directly related to higher levels of burnout and reduced organizational commitment (Leiter & Maslach, 1988). Supervisors provide considerable feedback to mental health counselors and it seems reasonable that negative unpleasant experiences, which can take the form of negative evaluations or inadequate support, would contribute to poorer worker work outcomes. These findings highlight the unique contribution of people as a source of work-place stress.

Even among mental health counselors, disparities exist based on institutional settings (Raquepaw & Miller, 1989). Research has consistently shown that mental health counselors fare worse when working at agency settings than they do in private agencies (Sprang, Clark & Whitt-Woosley, 2007). For example, a national survey of psychologists

conducted by Rupert and Morgan (2005) provided novel insight into work setting differences and their relation to burnout. Particularly, researchers found that males in group practice reported significantly greater levels of emotional exhaustion than men in solo or agency settings, whereas women reported higher levels of emotional exhaustion in agency settings. Further, higher levels of personal accomplishment were attributable to practicing in a solo and group setting. A replication (Rupert & Kent, 2007) of the previous study found support for the notion that mental health staff in solo and group settings fare better than those in agency settings. Specifically, both solo and group practitioners reported higher levels of personal accomplishment, and fewer sources of stress than agency respondents. Raquepaw and Miller (1989) reported that burnout symptoms, such as high levels of emotional exhaustions and low levels of personal accomplishment, were most evident in psychotherapists who worked at least part time in an agency setting.

Further breakdown in the work-context reveals that community mental health staffs consistently fair worse than their counterparts in hospital and private agencies. In a study conducted by Prosser and colleagues (1996), community-based mental health staff scored significantly higher on the General Health Questionnaire (GHQ) and experienced higher levels of emotional exhaustion compared to hospital-based staff. Though showing a lack of burnout overtime, after three years, community based staff still showed poorer mental health than their counterparts. Despite mean burnout levels of low to medium in a sample of counseling psychologists (Vredenburg, Carlozzi & Stein, 1999), those in private settings reported significantly lower levels of burnout than those in hospital settings. Community staff frequently report high amounts of overload (Prosser et al.,

1997). This may be a central piece in explaining these disparities. Many of the differences that exist between practice settings, leading to variations in the dimensions of burnout, are based on a number of work demands, such as time allocated towards paperwork and administrative tasks, increased caseloads, and dealing with negative clients (Rupert & Kent, 2007). Therapists working in a private setting may inherently have greater autonomy in setting one's schedule, selecting manageable clients, and limiting administrative tasks thus limiting the amount of overload that contributed to symptoms of distress and burnout (Rupert & Morgan, 2005).

Empathy

Definition and history of empathy. Empathy has its roots from the German word *Einfühlung* ("feeling into" something) that was used to describe a tool for analyzing works of art and nature. The experimental psychologist, Titchener (1909) translated it in English as empathy, which he later (1915) described it as a an act of feeling oneself *into* a situation, separate from the German word for sympathy (*Mitgefühl*) which he termed as feeling *together* with another (Bucheheimer, 1963). This terminology i.e., feeling into and feeling together, differentiates these two constructs which is important. For example, research dealing with affective experiences to another's suffering has shown that empathy, sympathy and distress are related, yet distinct vicarious responses (Fultz, Schaller & Cialdini, 1988). Further, while sympathy entails the formation and experience of feelings (e.g., vicarious emotional response) in response to others in social situations, empathy necessitates a convergence of behavior (Bucheheimer, 1963). There is a lack of general consensus on the definition of the construct of empathy. Eisenbergh and Strayer (1991) contend that, "in reality, there is no correct definition of empathy, just different

definitions” (p.5). There is, however, consistency in the facets that comprise this prominent, yet elusive construct.

Carl Rogers (1980, as cited in Greenberg, Watson, Elliot & Bohart, 2001, p.85), a prominent psychotherapist, in his earlier writings defined empathy as:

The therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings and struggles from the client’s point of view. [It is] this ability to see completely through the client’s eyes, to adopt his frame of reference. (p. 85, as cited in Greenberg, Watson, Elliot, & Bohart, 2001, p.380) ...It means entering the private perceptual world of the other....being sensitive, moment by moment, to the changing felt meanings which flow in this other person. It means sensing meanings of which he or she is scarcely aware... (p. 142, as cited in Greenberg, Watson, Elliot & Bohart, 2001, p. 380).

Based on this definition, Roger’s concept of empathy rested largely upon a deep understanding of the client’s experiences and feelings. Davis (1983) describes empathy as the “reactions of one individual to the observed experiences of another” (p.113).

Although, similar to that of Rogers (1957) in that it is an *other-focus*, Davis’s definition includes the reactions of the observer as serving a vital role in the experience of empathy, a component (e.g., reflecting statements) that Roger’s sought to downplay as important of empathy, though he later acknowledged (Rogers, 1975).

Hoffman (1984) bridges these departing definitions by encapsulating them into two main processes: (a) a cognitive process that renders the perceiver the ability to interpret the internal states of another, such as thoughts and feelings, and (b) an affective

processes that leads to a vicarious response to another (Davis, 1983). As such, Hoffman (2008) defines empathy as, “an emotional state triggered by another’s emotional state or situation, in which one feels what the other feels or would normally be expected to feel in his situation” (p. 440). This view is furthered by Eisenbergh and Strayer (1991) who contend empathy to be an actual emotion that arises when an individual’s emotional state is similar, or in congruence with another. Despite the recognition of both cognitive and affective components of empathy, this view has been criticized as being too broad, thus a more explicit conceptualization of the ways in which people relate towards one another seems necessary.

Elliot and colleagues (2011) define empathy as a higher-level category comprised of various modes. First, empathic rapport, a phenomenon that seems a prerequisite to most therapists in the beginning stages of counseling, involves establishing a relationship between the counselor and client. This is fulfilled by the therapist taking a compassionate stance towards the client and a display of understanding for the plight the client presents with. Second, communicative attunement, a process oriented behavior, consists of an active and continual engagement to the client’s communication and unfolding experience within the therapy context. Last, person empathy (Elliot, Watson, Goldman & Greenberg, 2003), which encompasses both historical and present experiences, pushes the therapist to continually evaluate the experiences had by the client that contribute to the current experience of the client.

Models of empathy. Barrett-Lennard (1981) provides a clear conceptualization of empathy and the subsequent process. The cyclical model of empathy is comprised of three distinct components. Empathic Resonance comprises the therapist’s experience to the

observer. Expressed Empathy is the observer's view. Last, Received Empathy entails the perception and experience of the observer.

Davis (1983) delineated ways that people relate towards one another into four categories. Perspective Taking (PT) is the cognitive ability to take the perspective of another individual. In the therapy setting, the therapist is able to attune to and psychologically reenact the experience of the client. Empathic Concern (EC) is experiencing feelings of concern for the other's misfortune or plight. Personal Distress (PD) involves observer experience of discomfort, such as anxiety and sadness, in reaction to the experience of others. Finally, Fantasy (FS) is indicative of the transposition of one's *self* into the thoughts and feelings of fictitious characters in books, movies and plays. Because the following study will use a measure of empathy based on this model (Interpersonal Reactivity Index (IRI); Davis, 1980) the researcher will briefly support talk about these four categories.

Perspective taking abilities have been shown to develop at the early stages of our lives. It is this ability that Gallese (2001) noted "it is this experience that enables us to directly recognize others not as bodies endowed with a mind but as persons like us" (p.176). Research on Theory of Mind (ToM) has aided in understanding social processing. The basic premise of ToM is that individuals are capable of ascertaining the thoughts and intentions of others based on shared experiences. So, for example, a counselor may ask a client if she feels devalued after learning that the client maintains the household, yet her children and husband never acknowledge her contributions. Though processing of cognitive states has been shown to be more indicative of ToM and empathy for processing emotions, both have been shown to share similar neural networks (Völlm

et al., 2006). More recent advances in technology, specifically neural imaging capabilities have allowed researchers to observe the effects of empathy on neural pathways (Völlm et al., 2006). Evidence of mirror neurons has revealed a neural matching mechanism that underlies the empathy process. In other words, brain cells are activated when individuals observe another performing a goal directed behavior which subsequently allows the observer to exhibit a similar experience—or place themselves in another’s shoes (Gallese, 2001; Gallese, 2003). Therefore, whether innate or established through experience, evidence has demonstrated individuals are capable of inferring sensations, pains and emotions through some form of neural processing system (Gallese, 2001).

Empathic concern can be categorized as an emotional response that manifest in the form of sympathy and compassion, or distress and sadness for the person (Batson, Eklund, Chermok, Hoyt & Ortiz, 2007). This process entails an emotional congruence with that of the observed, yet can be separated to elicit helping behaviors. The capacity for empathic concern or emotional connectedness has been shown to start in the early years (Zahn-Waxler & Radke-Yarrow, 1990) and has been shown to be vital in helping behaviors (Batson et al., 2007). Batson and Coke (1981) presented a model of helping behavior to augment research on empathy. The empathy-altruism model states that individuals are motivated to help due to two different responses: personal distress (e.g., worry) and empathic concern (e.g., sympathy). Whereas the former motivates an individual to relieve one’s own distress, the latter seeks to reduce the distress of another, thus comprising a selfless or altruistic act. Support for this model was found in a study conducted by Schroeder, Dovidio, Sibicky, Matthews and Allen (1988). Results revealed

that participants in the easy escape/personal distress conditions were significantly less likely to help than those in the other conditions (e.g., easy escape/empathic concern).

Personal distress has been generally defined as a self-focused, aversive reaction to the plight and reaction(s) of another, which typically may manifest as anxiety or distress in the observer (Zahn-Waxler & Radke-Yarrow, 1990). Keeping in line with helping (or prosocial) behaviors, those who experience personal distress are inclined to provide support in an effort to alleviate their distress; when escape is easy, however, personal distress decreased helping behaviors (Schreoder et al, 1988).

Fantasy can be seen as the tendency for an individual to place themselves imaginatively into the feelings and actions of characters in books, movies, and plays (Davis, 1983). This dimension is cognitive in nature as it requires the individual to image and infer mental states of another. Lee, Guajardo, Short and King (2010) found that the fantasy empathy correlated with Ocular level empathic accuracy ability, a test that requires participants to infer mental states of human faces on photographs.

Taken together, the aforementioned constructs lend support for the multifaceted nature of empathy. These components uniquely contribute to, yet work in tandem to produce both cognitive and empathic responses, which are indicative of empathy (Davis, 1983; Miville, Carlozzi, Gushue, Schara & Ueda, 2006; Negd, Mallan, & Lipp, 2011).

Empathy in the counseling setting. The curative nature of empathy has garnered robust theoretical and experimental support; however, over the last few decades more focus research has focused on the therapeutic alliance (or relationship), which includes empathy as a component (Feller & Cottone, 2003).

Many have debated whether to consider the therapeutic relationship a necessity of change or a component underlying the process that leads to change. Roger's (1957) assertion that the relationship is "necessary and sufficient" is common knowledge in counseling circles. However, Strupp (1978) argues against this belief. Strupp identifies the relationship as an important factor, yet insufficient without the technical skills that therapists bring to their work (1978). Whether the relationship is enough seems to be of least importance compared to whether it is efficacious in and of itself. Over the years, the American Psychological Association has issued many task forces to assess the effectiveness of the therapy relationships on outcomes. Based on the empirical evidence examined, the task force has consistently found support for the curative effects of the therapeutic relationships. Specifically, common conclusions have been:

- The therapy relationship makes substantial contributions to psychotherapy outcome independent of the specific type of treatment (Norcross & Wampold, 2011).
- Efforts to promulgate practice guidelines or evidence-based lists of effective psychotherapy without including the therapy relationship are seriously incomplete and potentially misleading on both clinical and empirical grounds (Silverman, 2001).
- Adapting or tailoring the therapy relationship to specific patient needs and characteristics enhances the effectiveness of treatment.

Nevertheless, the therapeutic relationship has surely come to be viewed as a “relational enterprise” that is complex and worthy of rigorous study due to its implications for process and outcomes of psychotherapy (Norcross & Wampold, 2011).

It is generally viewed that therapeutic alliance (or relationship) entails an affective and conscious and active collaboration between the therapist and those with whom they serve. Bordin (1979) narrows this view, positing that alliance consists of three features: collaboration and agreement of goals, task (s) assignment, and development of bonds between therapists and those with whom they treat. Particularly, strength of the client-counselor relationship has been associated with positive therapy outcomes (Norcross & Wampold, 2011), even across various treatment modalities (e.g., Arnow et al., 2013). Relationship and outcomes studies have also found small to moderate associations for youth therapy (Karver, Handelsman, Fields & Buckmann, 2006). The therapeutic relationship has been shown to have positive effects on therapeutic outcomes, though the underlying component of empathy is of particular interest to the study at hand, thus will be explored.

Empathy and client experiences in counseling. Of these core tenants making up the therapeutic relationship, counselor empathy has been viewed as essential to outcome. Rogers (1957) argued in support of empathy as one of the “necessary and sufficient conditions of therapeutic personality change” (p.95). Similarly, the American Psychological Association Task Force on Evidence-Based Therapy Relationships has established empathy as an empirically based element of the therapeutic relationship and recommends training programs to implement this as a competency standard in educating counselors about essential relationship elements. As such, empathy is seen as an

important aspect of the client-counselor relationship even across counselors who subscribe to different theoretical orientations. One study in particular (Fischer, Paveza, Kickert, Hubbard, & Grayson, 1975) found no significant differences between theoretical orientation and counselor expression of essential relational elements including empathy, warmth, and genuineness. Mental health counselors who embrace a specific type of model i.e., scientist versus practitioner, may inherently exhibit various level of empathy. For example, Hall, Davis and Connelly (2000) found that female therapists dispositional levels of empathy, namely empathic concern and perspective taking, were different based on their occupational status (i.e., practitioner versus scientist). These findings highlight potential variability amongst mental health counselors.

Every interpersonal interaction involves communication. This too is true in the counseling relationship wherein the focus of exploration can involve experiences, thoughts, feelings, and behaviors in the past, present and future. Because empathy is considered to be a necessary feature of psychotherapy, this too must be communicated by the therapist. Understandably, it is safe to assume then that therapy cannot be beneficial if this does not take place (Rogers, 1957). There are however conditions that impede interpersonal exploration and counselor expression of empathy, specifically (Truax & Carkhuff, 1965). Grater and Claxton (1976), for example, hypothesized that clients would change topics (changing target of discussion) during session as a result of reduced counselor empathy (measured by two experienced raters; inter-rater reliability was .88). The researchers analyzed 30 transcripts of counseling sessions conducted by seven (three females and two males) doctoral interns or practicum students with counseling experience. Results revealed that, prior to topic a change in topic by the client; the

counselor's level of empathy was lower than compared to his average empathy level over the course of the session. Similar results were found in a study by Heck and Davis (1973) wherein not only was base rates empathy levels different between counselors but that counselors' levels of expressed empathy changed across different [therapy] conditions. Researcher suggesting that physiological responding is also related to empathy in the counseling setting (Robinson, Herman, & Kaplan, 1982). These findings extend support for the variable nature of empathy in counselors and their communication in therapy (Traux & Carkhuff, 1967).

Empathy and therapy outcomes. Meta-analysis studies on therapy outcomes have generated robust support for the utility of empathy in counseling. Greenberg, Watson, Elliot and Bohart (2001) conducted a meta-analysis of the relation of empathy to psychotherapy outcomes. Encompassing 47 studies from 1961 to 2000, involving 3, 026 clients, researchers found a medium effect size ($r=.32$), indicating that empathy as a whole accounted for approximately 10% of the variance in psychotherapy outcome. In a more recent meta-analysis (Elliot, Bohart, Watson, & Greenber, 2011), support for the link between empathy and psychotherapy outcome was also found. Elliot et al. (2011) found that not only was therapist empathy a moderately strong predictor of therapy outcomes ($r = .31$), but client, as opposed to observer and counselor self-ratings on empathy scales, were stronger predictors of client outcomes ($r = .32$). This was also true in a study by Kurtz and Grummon (1972) wherein client reports of counselor empathy explained as much as 44% of the variance in outcome measures. Despite these findings, it is hard to draw causal conclusions between empathy and therapy outcome measures. In other words, research determining whether empathy is a causal or correlative factor in

relation to therapeutic outcomes is still scant (Greenberg, Watson, Elliot & Bohart, 2001). Hence, a more thorough review of research on empathy and outcomes will be discussed.

Empathy has been shown to contribute significantly to the counselor/client relationship. For instance, empathy increases such things as client satisfaction, safety, and therapy longevity (Greenberg, Watson, Elliot & Bohart, 2001). Kasarabada, Hser, Boles and Huang (2002) found positive patient perceptions of counselors were positively associated with treatment retention and psychological functioning in a sample of patients in a drug treatment facility. Clients who feel understood and perceive their counselor as taking an active interest in them are more likely to rate their therapist and counseling experience more favorably (Grigg & Goodstein, 1957). This too extends to client investment and engagement in therapy, as those more satisfied are likely to be more compliant (Greenberg, Watson, Elliot & Bohart, 2001). Clients who feel understood also tend to feel safe which allows for self-disclosure and deeper processing of their experience (Kurtz & Grummon, 1972; Traux & Carkhuff, 1967).

Counselor attributes are an important factor in establishing and maintaining the therapeutic relationship and are often cited by clients who report positive therapy outcomes. For instance, Strupp, Fox, and Lessler (1969) reported that clients who found therapy to be successful perceived their therapist to be, “warm, attentive, interesting, understanding, and respectful” (p. 116). Similarly, in a three year follow-up study of 99 former clients at a community mental health agency (Kirchner & Hogan, 1982), 85% of client reported therapy to be successful. Participants who felt that the therapist was interested in them reported therapy to be helpful. Hall and colleagues (2000) compared dispositional empathy levels in a sample of psychologists and their self-report ratings of

their professional effectiveness. Respondents with higher scores on empathic concern and perspective taking, and lower scores on personal distress reported greater satisfaction with their work.

Empathy and Burnout Intersection

Researchers have argued that empathy serves as a protective factor against burnout in human service workers because it allows for effective communication interactions. In fact, the Empathetic Communication Model of Burnout offered by Miller et al. (1995) shows that empathy facilitates effective communication with clients/patients, which subsequently prevents burnout. Empathic responding is necessary for counseling relationships; however, it can also become a hindrance if not properly managed. Black and Weinreich (2003) noted that empathic responding, particularly affective (versus cognitive or behavioral) responding, can exacerbate symptoms that lead to compassion fatigue and burnout. The work of Miller, Stiff, and Ellis (1988) lends support to these claims. The authors differentiate between two types of empathy, *emotional contagion* and *empathic concern*. Emotional contagion is an affective response wherein the observer's emotions are in parallel to those of another person, whereas empathic concern elicits emotions that are not parallel to those of another. For example, a counselor who is consistently sad while talking to severely depressed clients may be experiencing emotional contagion. On the other hand, a female counselor may experience concern for a couple on the brink of divorce but not share in the clients' anger.

There is cause to believe that emotionally fusing with clients can be deleterious. Zahn-Waxler and Radke-Yarrow (1990) noted that emotional interdependency can

become too “fluid” between people which can subsequently damage development. This idea may be best highlighted by Maslach (1982) who stated:

Understanding someone’s problems and seeing things from him or her point of view should enhance your ability to provide good service or care. However, the vicarious experience of that person’s emotional turmoil will increase your susceptibility to emotional exhaustion. Emotional [contagion] is really a sort of weakness or vulnerability rather than a strength. The person whose feelings are easily aroused (but not necessarily easily controlled) is going to have far more difficulty in dealing with emotionally stressful situations than the person who is less excitable and more psychologically detached (p.70).

Implications for attenuating one’s emotions to be parallel to that of another have garnered further support. In a sample of nurses, Omdahl and O’Donnell (2001) found that emotional contagion accounted for significant variance facets of burnout, including emotional exhaustion and reduced occupational commitment.

Based on the previous arguments, empathy as a whole may lead to the development of burnout symptoms. However, Thomas (2013) departs from this all-encompassing view of empathy and suggests that it is the response of personal distress that makes individuals, in this case counselors, susceptible to negative health outcomes, including compassion fatigue and burnout. Skorupa and Afresti (1993) suggested that burnout may occur in the counseling setting as a loss of empathy for the client (Maslach, 2001), which can take the form of personal distress, a self-oriented response to distressing stimuli. Thomas (2013), for example, found that higher rates of personal

distress significantly predicted higher levels of burnout levels in a sample of clinical social workers. Likewise, Day and Chambers (1991) found that personal distress was positively related to all three subscales of the MBI; empathic concern and perspective taking were negatively related to depersonalization and personal accomplishment. Williams (1989) reported that emotional empathy significantly and positively correlated with both emotional exhaustion and personal accomplishment. Increased personal distress has also been linked to diminished therapeutic effectiveness in therapists, which can contribute to diminished personal accomplishment (Hall, Davis & Connelly, 2000). This imbalance in empathy levels (cognitive and emotional) can have negative consequences in helping professions, such as difficulties in detaching one from client problems (Williams, 1989).

Counselors with high levels of depersonalization (or disengagement) can impart significant harm on their clients. This can take the form of clinical abandonment wherein the counselor prematurely terminates with a client. Disengagement can take many forms, such as lack of preparation for interviews, aversion towards seeing clients, failure to keep appointments, lack of focus in counseling sessions, shallow processing of session content, disrespect of clients, depersonalization of clients, and so forth.

Depersonalizing clients, as stated previously, involves feelings of callousness towards them. However, a form of distancing or disengagement from clients may not necessarily be negative. According to Kahn (1990, p.694), personal disengagement refers to “the uncoupling of selves from work roles; in disengagement, people withdraw and defend themselves physically, cognitively, or emotionally during role performances.” Hoschchild (1983) noted that employees detach themselves from their work and

withdraw cognitively and emotionally. A moderate amount of depersonalization has been shown to be an adaptive coping strategy when dealing with high job demands and intense emotions (Lief & Fox, 1963). For instance, Sonnentag, Binnewies and Kinstanz (2010) conducted a 12-month long longitudinal study with 309 human service employees exploring the impact of job demands and psychological detachment from work and psychological health and work engagement. Results found that psychological detachment buffered the effects of high job demands on psychosomatic complaints and decrease in work engagement.

Many antecedents for burnout among mental health counselors have been noted. Over-involvement has been shown to significantly correlate with dimensions of burnout (Rupert & Morgan, 2005). Specifically, in their meta-analysis, Lee, Lim, Yang and Lee (2011) found that over-involvement was significantly correlated with emotional exhaustion, depersonalization and personal accomplishment (Ackerly et al, 1988). Over-involvement was shown to be most closely associated with emotional exhaustion however, revealing the deleterious effects that can accompany the interpersonal work of mental health professionals.

Self-Care

The work of mental health professionals can take many forms and, often, incorporate multiple responsibilities. The battle between self, versus other care is indicative of the human experience, though it becomes more prominent for those who are attuned to the emotional needs of others (Skovholt & Trotter-Mathison, 2014). Maintaining a balance between these two extremes of caring aids in maintaining vitality,

caring and professionalism, all of which aid in the success of those in the helping profession (Skovholt, Grier & Hanson, 2001). No doubt these responsibilities and level of caring can take a toll on many facets of individual functioning, and if left unchecked, can lead to distress and eventually burnout. Though self-care has garnered support for reducing negative health related symptoms, particularly burnout, there is yet to be an empirically sound measurement utilized by the masses.

Self-care is a term used in many academic and professional disciplines, yet lacks an agreed upon definition (Richards, Campenni & Muse-Burke, 2010). For example, Bickley (1998) vaguely operationalized self-care as a self-initiated behavior that promotes general health and well-being. Myers et al (2012) defined it as behaviors that promote physical and emotional wellbeing. For the purposes of this study self-care will be defined as the maintenance and promotion of emotional, physical, mental, spiritual and overall wellbeing (ACA, 2014; Section C, p.8).

Self-care importance. Impairment can take many forms in helping professionals, including distress, compassion fatigue and burnout. Self-care, though, has been regarded as a preventative tool for many forms of impairment and has been predictive of worker characteristics, such as job satisfaction, productivity and career longevity. Research on wellness has too documented the beneficial effects of self-care practices on psychological and physical health. Specifically, self-care activities such as spending time with family and friends, time management, physical exercise, utilization of social support (e.g., supervisors), leisure activities, hobbies and meditation and spiritual practice have been directly linked to higher levels of satisfaction and wellness. Physical self-care (or

resiliency) strategies have been shown to be indicative of health among individuals working in the public service sector (Gerber et al., 2014).

In addition to wellness, empirical support for self-care as a preventative measure for impairment has been established (Venart, Vasso, & Pitcher-Heft, 2007). Self-care practices, such as exercising, leisure activities, personal therapy, depersonalizing and reducing caseloads have been shown throughout studies to stave off impairment manifesting as depression, anxiety and burnout.

In his review of research on spirituality and religion, Moberg (2008) found that spirituality had positive relationships with various measures of life satisfaction, psychological wellbeing, and both physical and mental health across studies. Similarly, Kirby, Coleman and Daley (2004) found that spiritual beliefs significantly predicted psychological wellbeing (PWB) in a sample of frail and non-frail adults. Moreover, spirituality moderated the negative effects of frailty on PWB. Briggs and Shoffner (2006) found support for the preventative effects of spirituality on depression. In their study, spiritual wellness (meaning and purpose in life) significantly predicted lower levels of depression in for both older adolescents and midlife adults. Engagement in spiritual activities, such as prayer and meditation has also been shown to relieve psychological stress and even death anxiety (Moberg, 2008).

Counselor utilization of self-care. Despite the extant literature purporting self-care practices to be beneficial, if not vital to overall health and wellbeing, mental health counselors have been known to find it difficult to engage in such practices due to various barriers (Bearse, McMinn, Seegobin, & Free, 2013). Many suggest marginal self-care

utilization among mental health counselors are the result of an over emphasis on the meeting the needs of those whom they serve, at the expense of their own needs. Venart et al (2007) likened it to a failure to prioritize oneself on his or her “to-do list” (p.62). It appears likely that being consumed by one’s work can deplete a counselor’s energy to attend to other facets of his or her life. For example, Yalom (2002) articulated this point in the following statement:

Too often, we therapist neglect our personal relationships. Our work becomes our life. At the end of our workday, having given so much of ourselves, we feel drained of the desire for more relationship. (p.252)

From a review of relevant literature, Carroll, Gilroy and Murra (2013) subsume self-care activities under four categories: intrapersonal work, interpersonal support, professional development and support, and physical/recreational activities. Similarly, O’Halloran and O’Halloran (2001) offered four categories of self-care strategies: (a) biobehavioral strategies, (b) affective and cognitive strategies, (c) relational strategies, and (d) spiritual strategies. Biobehavioral strategies include nutrition, exercise, sleep, medication, and relaxation and play. Affective and cognitive strategies may involve self-care plans, resource lists, positive self-statements, inspirational readings, humor, journaling, and crying. Relational strategies require interpersonal interactions and may include forming personal and professional support systems, personal counseling and companionship through pets. Spiritual strategies that emphasize a connection to a greater source may involve religious practice, rituals, creating meaning in life, or a connection with the environment through activities such as hiking, camping, gardening and traveling.

Bober and Regehr (2006) found that a sample of mental health and medical workers expressed perceived benefits of coping strategies, such as leisure and self-care practices; however, no association was found between the belief in perceived benefits and actual time allotted for these activities.

The benefits of being a client in therapy are plenty, including personal insight, perspective gain, awareness of one's counterproductive thoughts and behaviors, psychoeducation, and experiential learning that promotes wellness. Venart and others (2007) noted that counselors should "proactively establish a relationship with a therapist so they have a trusted resource during a crisis or transition" (p.59). In a study by Gilroy and colleagues (2015), a sample of female therapists reported on their experiences in counseling. Particularly, as it related to their alleviating their depressive issues, respondents noted therapist characteristics (e.g., empathy), therapeutic techniques (e.g., dream work), and addressing issues underlying depression (e.g., marital distress) to be most effective.

Many mental health counselors report having themselves been in psychotherapy (Gilroy, Carroll & Murra, 2015), though utilization is still limited. This view is highlighted in a study by Mahoney (1997) in that while 87.7% of psychotherapists (N=155) reported attending psychotherapy at some point in their life, less than half of women (46.5%), and a third of men (27.9%) reported attending therapy within the past year. This disparity may be explained by the stigma associated with therapy. For example, Carroll, Gilroy and Murra (2003) found that counselors' were more supportive of depressed counselors taking antidepressants than engaging in other forms of therapy (e.g., counseling). To explain this finding, the authors suggested that those with

depressive symptoms feared professional censure if they were to be open about their difficulties. Support for the previous sentiment is highlighted in a study by Gilroy et al (2001) in which one respondent noted “they were merciless ... when my depression became more clearly clinical and not amenable or responsive to peptalks [sic], they turned on me with a passion” (p.27).

Therefore, lack of utilization of personal therapy may be attributed to counselors not wanting to be seen as incompetent and unethical, both of which are likely to elicit criticism from colleagues and superiors (Carrol, Gilroy & Murra, 2003).

Mahoney (1997) renders a more positive view of self-care practices among mental health professionals which is in contrast with existing literature. More than half of respondents reported practicing meditation or prayer, and three out of four engaged in physical exercise. Most interesting was the rates at which respondents experienced personal therapy within the past year, which stood at one out of every three.

Group learning interventions aimed at providing education to clinical teams has shown promising results for reducing work-related stress. For example, in a sample of health workers, Sharkey and Sharples (2003) found reductions in various sources of stress intrinsic to the job. Participants also reported better scores of mental health, and perceived locus of control subscales. Moreover, ‘work-related pressure’ subscales showed a significant mean decreases at post-test. In other words, workers who participated in the intervention reported significantly less ‘fluctuations in workload’ and ‘dealing with relatives’, and highly significant differences in ‘difficulty dealing with

aggressive people', 'difficult patients' and 'involvement in life and death situations' (Sharkey & Sharples, 2006, p.6).

Mindfulness-based stress reduction interventions (MBSR) interventions have particularly shown promising results in alleviating negative health issues in counselors. For example, Shapiro, Brown and Biegel (2007) examined the effects of a MBSR intervention on stress in a sample of therapists in training. Fifty-four counselors in training, enrolled in a master's level counseling program, participated in 10 weekly classes in a Stress and Stress Management course (three hours per week) and a subsequent 8-week MBSR intervention which began three weeks after participants started the course and included weekly 2-hour sessions. The intervention included five mindfulness practices, including sitting meditation, body scan, Hatha yoga, guided loving-kindness meditation, and practices to bring mindfulness into day-to-day life (Kabat-Zin, 1982, as cited by Shipiro, Brown & Biegel). Findings revealed that, compared to the control group, those students who participated in in the MBSR intervention reported significant decreases in perceived stress, negative affect, state and trait anxiety, rumination, and significant increases in positive affect and self-compassion from pre/post intervention.

Self-care: Ethical imperative for counselors. Self-care is widely accepted in the psychology and counseling community as an imperative among professionals. Issues plaguing mental health professionals have engendered guidelines that center on engaging in self-care practices for the maintenance of professional competence and buffers to impairment. As such, in the last few decades, professional communities have broadened their view of self-care to that of attending to and caring for the self. Currently, the

American Psychological Association (APA) Code of Ethics on competence states “psychologists undertake ongoing efforts to develop and maintain their competence,” (APA, 2010, Section 2.03, p.5). Furthermore, psychologists are encouraged to “refrain from initiating an activity when they know or should know that there is a substantial likelihood their personal problems will prevent them from performing their work-related activities in a competent manner,” (APA, 2010, Section 2.06, p. 5). The American Counseling Association (ACA) Code of Ethics provides a more thorough description of impairment by stating that “counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired” (ACA, 2014, Section C.2.g., p.9). Indeed, these codes highlight the one of the most central principles across helping professions, that is, to benefit those who seek services and to ensure that no (intentional) harm is done. Nevertheless, competence can be developed and heightened through self-care practices largely based on the need for self-awareness and behaviors that contribute to the care of the professional, which would ultimately reduce impairment.

CHAPTER III

Method

Design

A non-experimental, correlational design was used for this study as a way to examine the relationships between and among the main study variables including the predictor variables, which were the empathy variables (e.g., empathic concern, perspective taking, and personal distress) and self-care, and the dependent variable, which was burnout as measured by the emotional exhaustion subscale of the MBI. Also, this study used a cross-sectional design as a way of making inferences about the sample at a single point in time.

Participants

The participants in this study were sampled from a population of mental health counselors employed at various agencies including: university counseling centers, hospitals, community mental health agencies and private practices. Both purposive and snowball sampling methods were used in the selection of agencies and recruitment of participants. The agencies were selected from a list of publically available sites; participants were recruited from the selected agencies. Also, participants were recruited through on-line formats (e.g., Facebook) or through professional counseling and

psychological listservs. Participation was entirely voluntary and confidential. Incentives to participate in the study either included a monetary allotment of \$2 if recruited from the agency or a chance to be entered into a drawing for one of ten amazon gift-cards valued at \$5 if recruited on-line. For those recruited from an agency setting, incentives were made available at the same time participants receive study materials, which allowed them to decline to participate while still receiving their monetary funds. Furthermore, incentives for participants recruited through professional counseling and psychological listservs and online formats (e.g., Facebook) were not made available until after data collection was complete. There were no statistical analyses performed to determine whether the incentives used in this study contributed to response rates.

Power Analysis

A statistical power analysis was performed using the program *G*Power 3.0.1* (Faul, Erdfelder & Lang, 2009) to provide sample estimation for the proposed study. More specifically, an a priori power analysis was utilized, as this provided the best estimation of the amount of participants needed to find some level of significant effect (i.e., p-values). With a target effect size $R^2 = .15$, alpha = .05, power = .80, and 2 predictors, the projected sample computed was approximately $N = 68$ for this *multiple regression: omnibus* test. Therefore, the proposed sample size of 68+ was more than sufficient for the goals of this study.

Instruments

A 120-item questionnaire was administered via paper survey as well as via an on-line format. The survey included items related to participants' levels of empathy,

perceptions of perceived engagement in self-care practices, burnout, and a brief demographic questionnaire. It was proposed that the survey would take no more than 30 minutes to complete.

Demographic questionnaire. The goal of this questionnaire was to obtain information on the age, gender, ethnicity, education level, job location, number of direct client hours per week, years of counseling experience and number of hours supervised per week. This information was used for descriptive purposes and for exploratory analyses unrelated to the main hypotheses analyses.

The maslach burnout inventory (MBI: Maslach, 1996, 3rd edition). This scale was used to measure mental health counselors' level of job burnout. The MBI was used to measure three dimensions of burnout: Emotional exhaustion (EE), depersonalization (DP) and personal accomplishment (PA). The EE subscale assesses the degree to which a counselor feels overextended and emotionally exhausted by his or her work. The DP subscale assesses the degree to which an individual becomes unresponsive and impersonal towards his or her client during the course of treatment. Lastly, the PA subscale assesses an individual's sense of competence, efficacy and accomplishment at his or her work.

The MBI is a 22-item self-report questionnaire, consisting of three subscales: (a) Emotional Exhaustion (e.g., "I feel emotionally drained from my work"), (b) Depersonalization (e.g., "I treat some service users as if they were impersonal objects"), (c) Personal Accomplishment (e.g., "I have accomplished many worthwhile things in this job,"). The participants score each item on a seven-point Likert scale, ranging from 0

(never) to 6 (everyday). Burnout is conceptualized as a continuous variable (as opposed to a dichotomous) so it should not be seen as a variable that is present or absent. Scores are computed separately for each factor and are coded as low, average, or high using cutoff scores that separate the distribution into thirds. Higher scores reflect greater levels of emotional exhaustion, depersonalization and reduced personal accomplishment.

Previous studies (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012) have argued for examining the three dimensions of burnout separately, as opposed to as a unified whole, citing complex relationships amongst the components, e.g., low correlations (Lee & Ashforth, 1996), and elucidating their unique effects on various outcome measures. Some researchers (e.g., Koeske & Koeske, 1989) have gone further to suggest that the tri-dimensional theory of burnout be dropped in favor of examining emotional exhaustion, the central component of burnout, at the exclusion of depersonalization and perceived efficacy. Yet, despite the caution raised by various researchers (Koeske & Koeske, 1989) of combining all three components of the MBI, the use of a global score of burnout and has yielded high internal consistencies. Buunk, Ybema, Gibbons and Ipenburg (2001), for example, calculated a Chronbach's alpha of .87 after summing all of the items in the MBI. It would seem that combining these scores would take away from the multidimensional nature of burnout, as purported by (Morse et al., 2012). However, some authors (e.g., Brenninkmeijer & VanYperen, 2003; Maslach, Schaufeli, & Leiter, 2001) have contended that focusing solely on individual components of burnout can take away from its full understanding and, quite possible, can represent a phenomenon that is not representative of the traditional view of burnout, that being a syndrome. Given careful consideration of these differing views of measuring burnout,

this study will elect to measure burnout as originally intended, that being measuring each component separately.

The MBI was normed on a sample that included service providers in the human services fields. Individuals were from the following occupations: police, counselors, teachers, nurses, social workers, psychiatrists, psychologists, attorneys, physicians, and agency administrators (Maslach & Jackson, 1981). Maslach, et al. (1996) reported internal consistency with coefficient alpha estimates of .90 for emotional exhaustion, 0.79 for depersonalization, and 0.71 for personal accomplishment. Data for test-retest reliability for the MBI have been reported. In a sample of graduate students in social welfare, and administrators in a health care agency (n=53), Maslach and Jackson (1981) reported reliability coefficients for the sub-scales as follows: .82 for EE, .60 for DP, and .80 for PA; all of which were significant beyond the .001 level (p.105). In this study, Chronbach's α was .91 for EE, .80 for DP, and .80 for PA.

Maslach and Jackson (1981, 1986) reported convergent validity for the MBI. Specifically, individual MBI scores were correlated with (a) behavioral ratings of co-workers and one's spouse, (b) job characteristics expected to contribute to burnout (e.g., high caseloads), and (c) measures of various outcomes that have been hypothesized to relate to burnout. Discriminant validity was also obtained by distinguishing between measures of various psychological constructs presumed to confound with burnout. According to Maslach and Jackson (1986), a comparison of subject's scores on the MBI and the Job Diagnostic Survey (JDS) (n=91) revealed a moderate negative correlation with both EE ($r = -0.23$, $p < 0.05$) and DP ($r = -0.22$, $p < 0.02$), and a slightly positive correlation with PA ($r = 0.17$, $p < 0.06$) (p.109).

The scores on the personal accomplishment subscale will be reverse scores so that all of the scales point towards a negative direction. Therefore, higher scores on the personal accomplishment subscale will represent a reduced sense of personal accomplishment, thus greater burnout.

The interpersonal reactivity index (IRI: Davis, 1980). This scale was used to measure mental health counselors' level of dispositional empathy. The IRI was used to measure both cognitive and affective dimensions of individuals' empathy. The cognitive dimension focuses on cognitive reactivity, that is, the ability to engage in perspective taking, while the emotional dimension, or emotional reactivity, assesses feelings towards another person while witnessing the plight of another. The IRI comprises four subscales: Perspective Taking (PT), Personal Distress (PD), Fantasy (FS), and Empathic Concern (EC). The PT scale measures the tendency to adopt the psychological point of view of other people. The PD scale measures the one's feelings of unease or discomfort while witnessing the plight of another person, which can subsequently prevent helping behaviors. The FS scale measures that tendency to transpose oneself into the feelings and actions of fictitious characters in books, movies, and plays. Finally, the EC scale measures the tendency to experience feelings of warmth, compassion and concern for other people.

The IRI contains 28 items, consisting of four subscales, which include: (a) Perspective Taking (e.g., "I try to look at everybody's side of a disagreement before I make a decision"), (b) Personal Distress (e.g., "I tend to lose control during emergencies"), (c) Fantasy (e.g., "I really get involved with the feelings of the characters in the novel"), and (d) Empathetic Concern (e.g., "I would describe myself as a pretty

soft-hearted person”). Each of the four dimensions contains 7 items that are evaluated on a scale ranging from 0 (Does not describe me well) to 4 (Describes me very well).

The IRI was normed on students attending an introductory psychology class at the University of Texas at Austin. The sample consisted of 579 male and 582 females. Davis (1980) reported high internal reliability coefficients on the four subscales for both men and women, ranging from .70 to .78. Standardized alpha coefficients for the 7 scales were as follows: Fantasy Scale .78 for males and .75 for females; Perspective Taking Scale .75 for males and .78 for females; Empathic Concern Scale .72 for males and .70 for females; Personal Distress Scale .78 for males and .78 for females (Davis, 1980). Test-retest reliability was measured over an elapsed time of 60 to 75 days and the reliability coefficients for the four empathy subscales were as follows: Fantasy Scale .79 for males and .81 for females; Perspective Taking Scale .61 for males and .62 for females; Empathic Concern Scale .72 for males and .70 for females; Personal Distress Scale .68 for males and .76 for females (Davis, 1980). In this study, Chronbach’s α was .75 for perspective taking, .71 for empathic concerns, and .81 for personal distress.

Davis (1983) reported concurrent validity for the IRI. Specifically, Davis tested the relationship between the IRI and two other measures of empathy The Mehrabian and Epstein Emotional Empathy Scale (1972) and the Hogan Empathy Scale (1969). The former scale measures the emotional component of empathy while the latter measures the cognitive component of empathy. As expected, the Mehrabian and Epstein Emotional Empathy Scale was significantly correlated with all four subscales of the IRI. Further, the Hogan scale was positively correlated with the cognitive PT scale but negatively correlated with the PD scale. A comparison of participants’ scores on the IRI to their

scores on the Jefferson Scale of Physician Empathy (JSPE) revealed a moderate correlation ($r = 0.45$, $p < 0.01$) (Hojat, Mangione, Kane & Gonnella, 2005).

The self-care assessment worksheet (SCAW: Saakvitne & Pearlman, 1996).

This self-report questionnaire was used to assess the degree to which mental health counselors engage in a range of self-care practices. The SCAW is divided into 6 main categories: physical, psychological, emotional, spiritual, work and balance. The physical self-care category addresses exercise and nutrition. The psychological self-care category lists activities that enhance mental wellbeing. Emotional self-care demonstrates activities that involve expression, self-understanding, and connection with others. The spiritual self-care category consists of activities involving personal meaning and beliefs. Work or professional self-care consists of activities that contribute to job satisfaction. Last, the balance category considers the sense of stability throughout one's personal and professional roles.

The SCAW contains 6 categories: physical (e.g., "Exercise"), psychological (e.g., "Make time for self-reflection"), emotional (e.g., "Spend time with others whose company you enjoy"), spiritual (e.g., "Spend time with nature"), professional (e.g., "Get regular supervision or consultation"), and balance (e.g., "Strive for balance within your work-life and workday"). Each category has a different number of items that signify a particular type of self-care activity. Participants are asked to rate the frequency of engaging in an activity on a scale from 1 (It never occurred to me) to 5 (Frequently). Higher scores for each subscale indicate a greater engagement in that dimension of self-care, while lower scores indicate minimal engagement.

The SCAW is not meant to be used for diagnostic purposes. Instead, the sole function of this assessment is to provide a description of how well the respondent is, or is not, engaging in self-care activities. Moreover, no psychometric properties have been established for the SCAW.

Procedure

First, administrators at each department were contacted via phone or e-mail to ensure that participants could be solicited within the agency. The administrators were provided with an oral, or e-mail script that identified the principal investigator, a brief description of the nature of the study, and contact information for further correspondence. Upon approval, administrators were presented with and asked to disseminate survey materials for the study to potential participants.

Included in the packet of materials was an informed consent and copies of each questionnaire. The first document presented was the informed consent, which provided participants with a description of the study as well as potential risks and benefits, incentives, and the contact information of the principal investigator to answer any questions. Participants were informed that the investigator had no affiliation with the agency, and that participation was completely voluntary and confidential. A statement indicating that if the participant agreed to participate they should proceed with answering the following questionnaires; if they refused to participate, they were directed to not complete the following questionnaires. Additionally, participants were asked to seal and place the pre-addressed envelope in a postal service drop-box. A debriefing statement was included at the end of the survey thanking participants for their participation

included the contact information of the researcher should they have further questions, or would like a copy of the results when the final manuscript was complete.

Participant recruitment was also completed using a snowball procedure via professional counseling and psychology listservs. These participants were provided a link that directed them to a Qualtrics survey. Once directed to the survey, an informed consent appeared which provided participants with a description of the study as well as potential risks and benefits, incentives, and the contact information of the principal investigator to answer any questions. After reading the informed consent, participants were asked to check a box stating that they either “agree to participate in the study” or “do not agree to participate in the study.” If they agreed to participate, they were taken to the start of the study; if they refused to participate, they were directed to the end of the survey. Furthermore, for those participants completing the online survey, they were taken to the end of the survey and were directed to submit contact information should they wish to be included into a drawing for the incentive.

Statistical Analyses

To address the first three hypotheses, and to determine the relationships among the variables, a series of regression analyses were conducted. The first series of regressions tested the empathy variables (i.e., perspective taking, empathic concern, and personal distress; IRI), separately, and self-care (SCAW) as predictor variables and burnout (emotional exhaustion; MBI) as the criterion variable. Next, post hoc testing was used to further explore the significance of the interaction terms.

In addition to the aforementioned analyses, a series of tests were conducted to examine the assumptions for multiple regression. First, the plots of the standardized residuals as a function of standardized predicted values were examined to determine whether the data was linear. Second, data plots and P-P plots were used to assess whether the data was normally distributed. Additionally, histograms were used to detect outliers, which were further examined using Mahalanoba's and Cook's distance. Third, given the nature of the data collection methods, it is assumed that participant scores are independent from one another. Finally, multi-collinearity diagnostics were conducted by examining the correlation matrix and variation inflation factor (VIF).

CHAPTER IV

Results

Results below examine the relationships among burnout, empathy, and self-care among mental health counselors. In this chapter, findings from descriptive statistics and the analyses and results for each of the four hypotheses will be discussed.

Descriptive Findings

The sample of participants consisted of 111 mental health counselors who were employed at mental health agencies in the United States. A total of 150 survey packets were distributed among the agencies and 85 survey packets were returned. The remaining participants were recruited on-line, though the exact medium in which they were solicited from cannot be determined. During the time of data collection, 45.0% mental health counselors were employed at a community mental health agency, 20.7% at a university counseling center, 19.8% at a private practice, 0.9% at a hospital/veterans affairs agency, 1.8% at a correctional facility, and 11.7% identified their work setting as other. Approximately 82.7% ($n = 86$) of the participants identified as female, 16.2% ($n = 17$) as males, and 1% ($n = 1$) identified as intersex and the mean age was 40 ($SD = 12.7$). Most of the participants identified as Heterosexual (61.3%, $n = 68$), followed by Gay/Lesbian (29.7%, $n = 33$), Bi-sexual (4.5%, $n = 5$), and Asexual (3.6%, $n = 4$). The majority of the

sample identified as Caucasian (82.0%, $n = 91$), followed by other (7.2%, $n = 8$), African American (3.6%, $n = 4$), Hispanic/Latino (3.6%, $n = 4$), Asian/Pacific Islander/Asian American (1.8%, $n = 2$), and Native American/American Indian/Alaskan Native (0.9%, $n = 1$). Pertaining to education status, the majority of participants had a master's degree (66.7%, $n = 74$), followed by doctoral degree (23.4%, $n = 26$), bachelor's degree (6.3, $n = 7$), and other (3.6%, $n = 4$). The average participant has practiced for 10.98 years ($SD = 9.9$), has an average weekly caseload of 16.3 ($SD = 9.9$) clients, and acquires an average of 2.1 ($SD = 6.6$) hours of supervision per week. A summary of the demographic variables can be found in tables 1 and 2.

MBI-HHS Subscale Scores

The EE subscale of the MBI depicted high rates of burnout among mental health counselors including 37.8% of those endorsing "Moderate" EE and 35.1% endorsing "High" EE. Approximately 27% endorsed "Low" levels of EE, which indicates that they did not endorse scores on that suggests burnout as measured by EE. The DP subscale of the MBI did not depict as high of rates of burnout with 62.2% of those endorsing "Low" DP, followed by 25.2% endorsing "Moderate" levels and 12.6% endorsing "High" levels of DP. Similarly, on the PA subscale of the MBI, 46.4% endorsed "High" rates of PA, followed by 38.7% who endorse "Moderate" levels and 14.4% who endorsed "Low" levels. Descriptive statistics for rates of burnout among mental health counselors can be found in table 3.

Correlations

A two-tailed Pearson's correlation test was conducted to explore the relationships among the main study variables. Of the predictor variables, PD was significantly, and positively correlated with the EE ($r = .187, p < .05$) and SCAW was significantly, negatively correlated with EE ($r = -.464$). Additionally, PD was significantly, negatively correlated with SCAW ($r = -.314$). Contrary to expectations, EC and PT were not correlated with EE. Correlations for the main study variables are presented in table 4.

ANOVA and Simple Linear Regression

To explore whether there were any significant differences in EE among the demographic variables, several one-way analysis of variance tests were conducted to explore group differences. The demographic variables including gender, sexual orientation, race, level of education, and type of work environment were considered. Results from the analyses revealed no significant relationships between the demographic variables and EE. Thus, none of the demographic variables were controlled for in the subsequent analyses.

Analyses of Major Research Questions

Analyses of Assumptions

Prior to testing of the research hypotheses, assumptions were examined for each of the regression analyses. First, linearity, normality, homoscedasticity, and independence were examined. Second, outliers were observed and tested to determine whether their influence on the model was significant, thus requiring their removal. Finally, multicollinearity among the main predictor variables was examined.

Linearity, normality, homoscedasticity, and independence of residuals. A series of histograms depicting standardized residuals were used to assess that the data was normally distributed. Similarly, plots of standardized residuals by standardized predicted values were examined to determine whether distributions were linear and maintained constant variance. Based on these findings, the assumptions of linearity, normality, homoscedasticity, and independence of residuals were met.

Multivariate outliers. Outliers were identified using Mahalanobis's distance (MD). This measure determines the extent to which cases are multivariate outliers, which is compared to a chi-square distribution, assessed at a significance level of $p < .001$. Results from this test revealed that nine cases were deemed significant outliers. As a result, these cases were further assessed using Cook's D. Cook's D is used to determine the effect of deleting a given case on the regression statistics. Cases were determined to be influential based on made by Cook (1977) and Stevens (1984), who recommended a Cook's D cut-off score of 1.0. Results revealed that Cook's D ranged from .000 to .025, which suggested that none of the cases were influential. Therefore, there were no cases excluded from the regression analyses.

Hypothesis 1(a,b), 2(a,b), and 3(a,b)

To test the main hypotheses, several hierarchical regression analyses were conducted. The recommendations offered by Aiken and West (1991) were followed to test the moderation hypotheses. Specifically, after the values of the three empathy variables (EC, PT, and PD) and SCAW were centered, the main effects of the independent variables and the interaction term were entered into the regression equation.

Based on the hypotheses, three separate analyses were conducted to produce three moderation models. The methods for the first analysis will be used for subsequent analyses when warranted.

Hypothesis 1a and 1b. In the first analysis, EC and SCAW served as predictor variables and were regressed onto EE which was the criterion variable. In the first step of the model, the predictor variables were entered simultaneous. Results showed that SCAW was the only significant predictor. Taken together, the predictor variables explained 21.6% of the variance in EE scores. In the second step, the interaction term between EC and SCAW was entered into the equation. Results revealed that the interaction term was significant, thus indicating that SCAW moderated the relationship between EC and EE ($\beta = .173$, $t[107] = 2.035$, $p = .044$). Additionally, the interaction term significantly contributed to the model by explaining 2.9% of the variance in EE above and beyond the main effects.

To examine the significance of the interaction term, simple slopes were created by plotting values one standard deviation above and below the mean of the moderator variable (i.e., SCAW), and each slope was tested to determine its significance (Aiken & West, 1991; Cohen & Cohen, 2003). Results of the post hoc tests revealed that none of the simple slopes were significant above or below the mean. These findings suggest that for mental health professionals in this study, irrespective of their levels of empathic concern, there was no significant difference in their EE scores whether they engaged low levels of self-care or high levels of self-care. See table 5 for statistical output.

Hypothesis 2a and 2b. In the second analysis, PT and SCAW served as predictor variables and were regressed onto EE. Results showed that SCAW was the only significant predictor. Taken together, the predictor variables explained 21.6% of the variance in EE scores. Additionally, results indicated that the interaction term was not significant, suggesting that SCAW did not moderate the relationship between perspective taking and emotional exhaustion ($\beta = -.053$, $t[107] = -.604$, $p = .547$). Thus, the interaction term did not significantly contribute any unique variance to EE above and beyond the main effects. See table 6 for statistical output.

Hypothesis 3a and 3b. In the final analysis, PD and SCAW served as predictor variables and were regressed onto EE. Results showed that SCAW was the only significant predictor. Taken together, the predictor variables explained 21.7% of the variance in EE scores. Additionally, results indicated that the interaction term was not significant, suggest that SCAW did not moderate the relationship between PD and EE ($\beta = -.141$, $t[107] = -1.603$, $p = .112$). Thus, the interaction term did not significantly contribute any unique variance to EE above and beyond the main effects. See table 7 for statistical output.

Table 1: *Descriptive Statistics*

	N	Mean	Std. Deviation
Age	110	39.98	12.697
Years of Experience	108	10.98	9.926
Average Number of Clients per Week	106	16.26	9.923
Average Number of Acquired Supervision	109	2.08	6.585

Table 2: Descriptive Statistics

	N	Percent
Sex	111	
Female	93	84
Male	17	15
Intersex	1	1
Sexual Orientation	110	
Heterosexual	68	61
Gay/Lesbian	33	30
Bi-sexual	5	5
Asexual	4	4
Race/Ethnicity	111	
Caucasian/White/European America	91	82
African American/Black	4	4
Hispanic/Latino	4	4
Asian/Pacific Islander/Asian American	2	2
American/American Indian/Alaskan Native	1	1
Other	8	7
Level of Education	111	
Bachelor degree	7	6
Master degree	74	67
Doctoral degree	26	23
Other	4	6
Work Setting	111	
Community Mental Health	50	45
University Counseling Center	23	21
Hospital/V.A.	1	1
Private Practice	22	20
Correctional Facility	2	2
Other	13	12

Table 3: Descriptive Statistics for the Subscales of the Maslach Burnout Inventory

Subscale N = 111	Min	Max	Mean	Std. Deviation
EE	0	51	22.92	10.797
DP	0	22	6.17	5.286
PA	19.00	48.00	37.5045	6.03305

Subscale for EE

Level	Percent	N
Low	27.0	30
Moderate	38.0	42
High	35.0	39

Subscale for DP

Level	Percent	N
Low	62.0	69
Moderate	25.0	28
High	13.0	14

Subscale for PA

Level	Percent	N
Low	14.0	16
Moderate	39.0	43
High	47.0	52

Table 4: *Correlations and Means Among EE, Empathy Sub-Scales and SCAW*

	EE	EC	PT	PD	SCAW
Emotional Exhaustion	—				
Empathic Concern	-.038	—			
Perspective Taking	-.084	.127	—		
Personal Distress	.187*	.045	-.374**	—	
SCAW	-.464**	.063	.146	-.314**	—
M	22.92	21.71	20.05	7.56	168.83
SD	10.797	3.642	3.582	4.253	19.022

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Table 5: *Hierarchical Regression Analysis of Empathic Concern * Self-Scare Interaction as Predictors of Emotional Exhaustion*

Predictors entered						
in step		<i>F</i>	ΔR^2	<i>df</i>	β	<i>p</i>
Step 1		14.839	.216	2,108		.000
	EC				-.009	.916
	SCAW				-.464	.000
Step 2		11.560	.209	1,107		.00
	EC*SCAW				.173	.044

Note: EC = Empathic Concern; SCAW = Self-Care; EC*SCAW = Interaction of Empathic Concern and Self-Care.

Table 6: *Hierarchical Regression Analysis of Perspective Taking * Self-Scare Interaction as Predictors of Emotional Exhaustion*

Predictors entered						
in step		<i>F</i>	ΔR^2	<i>df</i>	β	<i>p</i>
Step 1		14.855	.216	2,108		.000
	PT				-.016	.849
	SCAW				-.462	.000
Step 2		9.967	.365	1,107		.000
	PT*SCAW				-.053	.547

Note: PT = Perspective Taking; SCAW = Self-Care; EC*SCAW = Interaction of Empathic Concern and Self-Care.

Table 7: *Hierarchical Regression Analysis of Personal Distress * Self-Scare Interaction as Predictors of Emotional Exhaustion*

Predictors entered							
in step		<i>F</i>	ΔR^2	<i>df</i>	β	<i>t</i>	<i>p</i>
Step 1		14.839	.216	2,108			.000
	PD				.046	.508	.612
	SCAW				-.450	-5.013	.000
Step 2		11.560	.209	1,107			.000
	PD*SCAW				-.141	-1.603	.112

Note: EC = Empathic Concern; SCAW = Self-Care; EC*SCAW = Interaction of Empathic Concern and Self-Care.

CHAPTER V

Discussion

In this chapter, a brief summary and discussion of the main research findings will be provided. Furthermore, implications of the research findings, suggestions for future areas of research, and a conclusion will be discussed.

Summary of Research Findings

The primary goals of this study were to explore the relationships among levels of dispositional empathy, self-care, and burnout among mental health counselors. Specifically, a series of regression analyses were conducted to determine whether the empathy variables (EC, PT, and PD), separately, SCAW, and the interaction between each individual empathy variable and SCAW significantly predicted burnout scores of mental health counselors.

Hypothesis 1a, 2a, 3a, and 4:

The results of the current study that sought to determine whether the empathy variables, separately, predicted burnout are mixed. First, EC was not significantly correlated with EE ($r = -.032, p > .05$). Additionally, multiple regression analysis revealed that EC failed to significantly predict EE scores. The lack of a significant association between EC and EE is puzzling to say the least. Empathic concern, which

entails the sharing of other's emotions, is an affective process, suggesting the use of emotional resources (Maslach, 2001). Studies have found that this type of emotional sharing can contribute to emotional fatigue and burnout (Omdahl and O'Donnell, 2001; Williams, 1989). One reason as to why this was not found to be the case in this study could be linked to an emotional regulatory processes. Counselors in this study who experience emotional reactions, such as compassion, may do so to a level that would not interfere with their abilities to function effectively with a client. That is, counselors who are able to maintain an emotional distance may be able to avoid the experience of emotional strain (Maslach, 1982), thus allowing them to effectively render support to others in need (Batson, Eklund, Chermok, Hoyt & Ortiz, 2007). Because empathic concern is thought to engender other-oriented feelings, such as compassion and sympathy, it is understandable that in the current findings it was not related to emotional exhaustion, which is shown to be more closely aligned with the chronic experience of self-oriented feelings, such as anxiety and anger.

Similarly, PT was not significantly correlated with EE ($r = .084$, $p > .05$). In addition, multiple regression analysis found that PT did not significantly predict EE scores. The lack of significance between PT and EE may be best explained by differences in their underlying mechanisms. Perspective taking abilities are the result of cognitive processes, whereas emotional exhaustion is typically brought about by the over use of emotional or affective resources (Maslach, 2001). Given that affective processes are not necessarily required to assume the perspective of another, it is reasonable then to assume that the participants' experience of emotional exhaustion would be unrelated to the degree to which they were able to understand the perspective of others.

Conversely, PD was found to be significantly correlated with EE ($r = .187$, $p < .05$). However, results of the multiple regression analysis found that PD did not significantly predict EE scores. While this finding supports previous evidence that have found a relationship between PD and EE, in the present study, the relationship does not appear to be as strong. This could be due range of score restriction. Because the variance of PD scores was limited, such that personal distress scores of the sample were confined to the lower end, this would lower the correlation between PD and EE scores.

Further, the results of the current study found that SCAW was correlated with EE ($r = -.464$, $p < .001$). Additionally, results from the multiple regression analysis found that SCAW significantly predicted EE scores and accounted for 21.6% of the variance in EE scores. These results are in line with previous studies that found that engaging in self-care is predictive of low burnout. Engaging in activities that serve to mitigate the stress that intrinsic in human service work is likely to prevent the development of emotional exhaustion.

Hypothesis 1b, 2b, and 3b:

The results of the current study produced some mixed results. First, the interaction between EC and SCAW was significant. However, there were no significant slopes, illustrating that EC scores predicted EE conditional upon SCAW scores, though irrespective of low, moderate, or high SCAW scores. In other words, counselors who experience empathic concern for clients are likely to exhibit reduced burnout, but only when they engage in self-care strategies. Interestingly, the current findings were unable to determine whether this effect was due to self-care at low, moderate, or high scores. These

findings may be best explained by the pick-a-point approach (Aiken & West, 1991) used to probe the significant interaction. According to Hayes (2013), this approach suffers can bring about unintended consequences. Specifically, Hayes (2013) maintains that determining the specific values of the moderator variable to estimate the conditional effect of the predictor variable on the criterion variable is arbitrary and can lead to different results. Such examples by Hayes (2013) includes the presence of a mean that is unrepresentative of the population, such that the mean is either too low or too high; Additionally, “low” and “high” values of the moderator might in fact be out of the range of measurement, thus the point at which the interaction is significant may not be detected. With this in mind, the failure to find the point at which SCAW moderated the relationship between EC and EE could be because the mean SCAW scores were skewed in the positive or negative direction. Consequently, with the pick-a-point approach used, the point at which self-care influenced the relationships between EC and EE is out of the range of measurement.

Contrary to these findings, the interaction between PT and SCAW was not significant. Similarly, the interaction between PD and SCAW was not significant. The latter two findings are not surprising given that empathy variables in these models were at best marginally correlated with EE scores.

Overall, these findings reflect the discrepancies that that are found among the studies examining the relationships among the aforementioned variables. For example, in some studies, significant associations were found between empathy and burnout, specifically emotional exhaustion (e.g., Day and Chambers, 1991; Omdahl and O'Donnell, 2001). However, similar to the current findings, other studies were not able to

find significant relationships among components of empathy, such as empathic concern and perspective taking, and burnout symptoms (Day & Chambers, 1991; Thomas, 2013). There are several additional factors that could have contributed to the lack of significant relationships among the study variables. For instance, the variability among studies in the types of scales used to measure the study variables could have contributed to the lack of significant relationships in the current study. Secondly, given that the sample is not representative of all mental health counselors, the full range of emotional exhaustion scores and empathy scores may not be represented in the current study (Hall, Davis & Connelly, 2000). This, in turn, might have contributed to a reduction in the relationships between the variables.

Implications

Implications for Practitioners

Overall, on average, this sample fell in the moderate burnout range. However, almost one third of the sample endorsed high levels of burnout in the form of emotional exhaustion. These rates of burnout, specifically emotional exhaustion, are comparable to those reported in other studies that explored burnout rates in mental health professionals (Ackerly, Burnell, Holder, & Kurdek, 1988; Rupert & Morgan, 2005; Maslach & Jackson, 1986; Vredenburgh, Carlozzi & Stein, 1999). This study also found some support for the role of dispositional factors in the experience of burnout. That is, the propensity to experience stress upon observing the plight of others is associated with emotional exhaustion. Though this finding seems intuitive, it is nevertheless noteworthy. As was mentioned previously, much of the work of mental health counselors involves

dealing with emotions, which presents a unique strain separate that is separate from occupations that do not involve human service work. It is reasonable then to assume that mental health counselors will encounter distressing content or experiences in the course of their work. However, those mental health counselors who are less able to manage their distress may, overtime, experience emotional strain or exhaustion. Therefore, counselors who lack effective emotion regulation skills such that they become easily distressed would likely benefit from learning distress tolerance skills in an effort to self-soothe. This also makes it even more imperative that mental health counselors engage in self-care, as this study has shown that counselors who engage in self-care are less likely to experience both personal distress and burnout.

Implications for Organizations

This study determined that a large proportion of currently employed mental health counselors endorse high degrees of burnout in the form of emotional exhaustion. With the knowledge that this study did not examine organizational variables, the current finds seem to warrant further extrapolation regarding implications for organizations. These findings should cause alarm to employers, as much of their workforce may be functioning in a lower than optimal capacity, which, in turn, may negatively impact client outcomes. For example, people are less willing to engage in helping behaviors when they become distressed (Batson et al, 2007; Batson & Cook, 1981; Schroeder, Dovidio, Sibicky, Matthews & Allen, 1988). Therefore, it is likely that mental health counselors who are prone to becoming distressed upon witnessing the plight of others, and who also feel emotionally taxed, may not provide the best care to clients or patients.

However, there are some encouraging findings from this study. Self-care was shown to buffer those who become personally distressed from experiencing burnout symptoms. This can serve as a signal for organizations to promote self-care to employees. For example, organizations can encourage employees to engage in activities that they find pleasurable or enjoyable, such as spending time with loved ones, exercising, reading, or eating health, among others. Organizations may even build into their system programs that encourage and facilitate self-care, such as free workshops on mindfulness, or designated time away from work-related activities, such as work retreats. Job demands, such as high caseloads and dealing with negative clients, have been shown to contribute to burnout symptoms (Rupert & Kent, 2007). Thus, organizations could benefit from working to reduce the strain on employees by limiting the amount of work demands, which may take form of reducing the amount of client contact hours, promoting autonomy in constructing work schedules, and making the completion of documentation and administrative tasks more efficient, among others.

Limitations

There are several limitations that may have impacted the findings of the current study. First, a correlational design was used, which limits the interpretation of the relationships among between variables. More specifically, correlational designs are able to establish that relationships exist between variables, though it is unable to determine causal relationships between the variables. So, for example, though the study found a significant relationship between self-care and emotional exhaustion such that increases in self-care predicted lower emotional exhaustion, it cannot be concluded that decreases in emotional exhaustion scores was caused by engaging in self-care behaviors. It could be

that emotional exhaustion scores were influenced by extraneous variables that were not measured in the study. Additionally, the cross-sectional design limits the interpretation and generalizability to the sample under investigation and the population reflecting the sample, at one point in time. Because a longitudinal design was not used, it is hard to observe trends and determine causal explanations for observed trends.

Second, this study limited the observation and interpretation of certain phenomena under investigation including burnout and empathy by measuring certain components and disregarding others. For example, emotional exhaustion was the only facet of burnout used in the main hypotheses in this study. Thus, only a component of burnout mental health professionals' experience of burnout was measured. This inherently limits the interpretation of the sample's experience of burnout as it has been shown that the other facets of burnout (i.e., depersonalization and personal accomplishment) uniquely influence workers' experiences. The inclusion of the other components of burnout could have generated different results. For example, as mentioned previously, there were no significant relationships between the empathy variables, empathic concern and perspective taking, and emotional exhaustion. However, if the relationships between these empathy variables and the other facets of burnout were examined, significant results may have been gleaned, as has in previous studies (e.g., Day & Chambers, 1991). Consequently, based on the exclusion of certain variables in this study, interpretations of the current findings could wrongly conclude that there are no significant relationships between empathy, as measured by the subscales of the IRI, and burnout.

Third, the composition of the sample may have impacted the findings in the current study. Overall, this sample of mental health counselors is reflective of the demographic of mental health service providers employed in the workforce, especially with respect to gender and race and ethnicity (Hamp, Stamm, Lin, & Christidis, 2016). However, there were a higher proportion of master's level counselors and those identifying as sexual minorities. It is unknown how these differences impacted the current findings.

Suggestions for Future Research

There are several notable directions that warrant further inquiry. First, it would be worthwhile to examine the relationships between the empathy variables and other facets of burnout, i.e., depersonalization and personal accomplishment. The inclusion of these other aspects of burnout would likely provide a more thorough depiction of the relationship between empathy and the burnout syndrome. Exploring different types of empathy on the burnout syndrome might also be of interest. For example, it would be notable to determine whether the burnout syndrome varies based on dispositional empathy versus state empathy. It might, for example, be found that empathically responding to clients contribute to therapist burnout, thus making it easier for supervisors and teachers to intervene in this process. In other words, it is reasonable to assume that the manner in which mental health counselors convey empathy to clients might be easier to adjust than by changing a counselor's dispositional empathy levels. Relatedly, it may be worthwhile to explore what role, if any, emotional intelligence may have on the relationship between empathy and burnout. For example, clinicians who have higher levels of emotional intelligence, such that they are able to attenuate or manage their

emotions and the emotions of others, may be less likely to experience distress and subsequent emotional exhaustion. Additionally, discerning whether different types of self-care uniquely buffer against burnout symptoms might help individuals and organizations create and implement interventions to combat burnout. Researchers would benefit in extending this work by employing a longitudinal study to ascertain causal relationships amongst the main study variables. Given that burnout has been conceptualized as a syndrome that evolves overtime, it seems sensible that studies assessing burnout begin to employ studies that are longer-term, despite the constraints of time and resources. Relatedly, the use of an experimental design would help to determine causal links and directionality among the main study variables. Furthermore, a replication of the current study with a more diverse, representative sample may generate more significant relationships among the main study variables and provide opportunities to explore comparisons among the sociodemographic variables.

Conclusion

In conclusion, the present study sought to add to and extend existing literature by examining the relationships among burnout, empathy, and self-care in mental health counselors. Despite the limitation of the current study, several noteworthy findings were gleaned. Specifically, self-care was shown to buffer the relationship between counselors who are prone to experiencing personal distress and their experience of burnout, specifically emotional exhaustion. Additionally, empathy variables, such as the ability to emotionally attune to and take the perspective of others, were not shown to contribute to the experience of emotional exhaustion. These findings highlight the need for the development and implementation of interventions tailored specifically to help reduce the

strain on mental health counselors.

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APPENDICES

APPENDIX A

The Interpersonal Reactivity Index

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter next to the item number. **READ EACH ITEM CAREFULLY BEFORE RESPONDING.** Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBE ME WELL				DESCRIBES ME VERY WELL

1. I daydream and fantasize, with some regularity, about things that might happen to me. (FS)
2. I often have tender, concerned feelings for people less fortunate than me. (EC)
3. I sometimes find it difficult to see things from the "other guy's" point of view. (PT) (-)
4. Sometimes I don't feel very sorry for other people when they are having problems. (EC) (-)
5. I really get involved with the feelings of the characters in a novel. (FS)
6. In emergency situations, I feel apprehensive and ill-at-ease. (PD)
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it. (FS) (-)
8. I try to look at everybody's side of a disagreement before I make a decision. (PT)

9. When I see someone being taken advantage of, I feel kind of protective towards them. (EC)
10. I sometimes feel helpless when I am in the middle of a very emotional situation. (PD)
11. I sometimes try to understand my friends better by imagining how things look from their perspective. (PT)
12. Becoming extremely involved in a good book or movie is somewhat rare for me. (FS) (-)
13. When I see someone get hurt, I tend to remain calm. (PD) (-)\
14. Other people's misfortunes do not usually disturb me a great deal. (EC) (-)
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. (PT) (-)
16. After seeing a play or movie, I have felt as though I were one of the characters. (FS)
17. Being in a tense emotional situation scares me. (PD)
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. (EC) (-)
19. I am usually pretty effective in dealing with emergencies. (PD) (-)
20. I am often quite touched by things that I see happen. (EC)
21. I believe that there are two sides to every question and try to look at them both. (PT)
22. I would describe myself as a pretty soft-hearted person. (EC)
23. When I watch a good movie, I can very easily put myself in the place of a leading character. (FS)
24. I tend to lose control during emergencies. (PD)
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while. (PT)
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me. (FS)
27. When I see someone who badly needs help in an emergency, I go to pieces. (PD)

28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.
(PT)

NOTE:(-) denotes item to be scored in reverse fashion

PT = perspective-taking scale

FS = fantasy scale

EC = empathic concern scale

PD = personal distress scale

A = 0

B = 1

C = 2

D = 3

E = 4

Except for reversed-scored items, which are scored:

A = 4

B = 3

C = 2

D = 1

E = 0

APPENDIX B
Maslach Burnout Inventory

For use by Sultan Magruder only. Received from Mind Garden, Inc. on July 1, 2015

MBI-Human Services Survey

Christina Maslach & Susan E. Jackson

*The purpose of this survey is to discover how various persons
in the human services, or helping professionals view their job
and the people with whom they work closely.*

Because persons in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

Instructions: On the following pages are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, write the number "0" (zero) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

How Often 0-6	Statement:
1. _____	I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under the heading "How Often." If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week but not daily), you would write the number "5."



www.mindgarden.com

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material for his/her thesis or dissertation research:

Instrument: **Maslach Burnout Inventory, Forms: General Survey, Human Services Survey & Educators Survey**

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Three sample items from a single form of this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

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Sincerely,

Robert Most
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APPENDIX C

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. Using the scale below, rate the following areas in terms of frequency:

5 = Frequently/Several times a week

4 = Occasionally/Several times a month

3 = Rarely/Less than once a month

2 = Never

1 = It never occurred to me

Physical Self-Care

___ Eat regularly (e.g. breakfast, lunch and dinner)

___ Eat healthy

___ Exercise

___ Get preventative medical care

___ Seek medical care when needed

___ Take time off when needed

___ Get massages

___ Engage in physical activity that you consider fun (dance, swim, walk, run, playsports)

___ Sex/intimacy

___ Get sufficient sleep

___ Contribute to your appearance

___ Take vacations

___ Take day trips or mini-vacations

___ Take time away from telephones, email, etc.

Psychological Self-Care

___ Take time for self-reflection (thoughts, judgments, beliefs, attitudes, and feelings)

___ Have your own personal psychotherapy

___ Write in a journal

___ Read literature that is unrelated to work

___ Actively decrease stress in your life

___ Engage your intelligence in areas outside of psychology

___ Allow yourself to receive from others

___ Say “no” to extra responsibilities sometimes

Emotional Self-Care

___ Spend time with others whose company you enjoy

___ Stay in contact with important people in your life

___ Give yourself affirmations/praise

___ Identify and seek out comforting activities, objects, people, or places

___ Allow yourself to feel and express emotion

Spiritual Self-Care

___ Spend time with nature

___ Engage in religion/spirituality

- ___ Meditate
- ___ Pray
- ___ Identify what is meaningful to you and notice its place in your life
- ___ Contribute to causes in which you believe (social advocacy, letters, donations, etc.)

Workplace or Professional Self-Care

- ___ Take a break during the workday (e.g. lunch)
- ___ Take time to chat with co-workers
- ___ Make quiet time to complete tasks
- ___ Identify projects or tasks that are exciting and rewarding
- ___ Set limits with your clients and colleagues
- ___ Balance your caseload so that no one day or part of a day is “too much”
- ___ Arrange your work space so it is comfortable and comforting
- ___ Get regular supervision or consultation
- ___ Negotiate for your needs (benefits, pay raise, etc.)
- ___ Have a peer support group

Balance

- ___ Strive for balance within your work-life and workday
- ___ Strive for balance among work, family, relationships, play, and rest

Appendix D

Request for Agency Participation

Greetings,

Your agency is being invited to participate in a research study exploring factors contributing to work-related stress among mental health counselors. This study is being conducted by Sultan Magruder, M.S., under the direction of Hugh Crethar, Ph.D., from the school of Applied Health and Education Psychology at Oklahoma State University. Mr. Magruder is a doctoral student in the Counseling Psychology doctoral program, and the data gathered will be used to fulfill the requirements of his doctoral dissertation. It is hoped that the findings from this study will be used to promote services that will increase counselor wellbeing, which in turn may facilitate increased job performance and subsequent client care.

A 120-Item survey will be administered via paper survey packets. The participants will answer questions related to factors that contribute to their work-related experiences. The survey will include a brief demographic questionnaire, and will take approximately 30 minutes to complete. Counselors will be awarded \$2 upon receipt of the survey materials, regardless of whether they choose to complete the survey.

Upon consent from your department, participants will be forwarded information pertaining to the study via e-mail. Survey packets will be distributed by department administrators to counselors employed at the agency. The information will describe the nature and purpose of the study, and will specify that participation is completely voluntary. Additionally, the e-mail will make explicit that participation is confidential, and that the researcher is in no way affiliated with the agency. Participants will be presented with an informed consent, again stating that participation is confidential and that they are able to discontinue participation at any time without penalty. Informed consent will be established by recognition of participants of their rights, responsibilities, awareness of risks and benefits and lastly, that they meet eligibility requirements to participate in the study.

The researcher will take full care to protect the anonymity of each participant, though full anonymity cannot be ensured. Participants' names will not be used, and demographic information included in the final write-up of this study will be presented in summary fashion. The datum will be stored in a locked file cabinet. Only the researcher will have access to the participant datum. Lastly, datum collected from the study will be destroyed in 5 years time after completion of the study.

Upon completion of the study, the department and participants may be provided the summary and findings. Request for individual responses will not be granted. This study

could potentially have a positive impact on addressing issues that impact counselors' job performance and client outcomes. Ways that your department could address these issues may be garnered from the current study. If your agency is interested in participating in the study, please forward the included informed consent statements to the counselors in your agency. Additionally, please contact the researcher to provide the number of counselors in your agency. If you have any questions or concerns, please do not hesitate to contact the researcher or advisor.

Thank you for your time and consideration.

Researcher: Sultan Magruder, M.S.
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*** For questions regarding participants' rights in the study, please contact:**

IRB Chair:
219 Cordell North
Oklahoma State University
Stillwater, OK 74078
Phone: (405) 744-3377
E-mail: irb@okstate.edu

Appendix E

Informed Consent

Greetings,

You are being invited to participate in a research study exploring factors contributing to work-related stress among mental health counselors. This study is being conducted by Sultan Magruder, M.S., under the direction of Hugh Crethar, Ph.D., from the school of Applied Health and Education Psychology at Oklahoma State University. Mr. Magruder is a doctoral student in the Counseling Psychology doctoral program, and the data gathered will be used to fulfill the requirements of his doctoral dissertation. It is hoped that the findings from this study will be used to promote services that will increase counselor wellbeing, which in turn may facilitate increased job performance and subsequently better client care.

Participation will include answering a 120-Item survey regarding questions related to factors that contribute to their work-related experiences. The survey will include a brief demographic questionnaire, and will take approximately 30 minutes to complete. Participation is completely voluntary. You will be allotted \$2, regardless of whether you complete the survey. You are able to decline and/or discontinue participation at any time without penalty.

The researcher will take full care to protect the anonymity of each participant, though full anonymity cannot be ensured. Names will not be used, and demographic information (e.g., age, ethnicity, years of experience) included in the final write-up of this study will be presented in summary fashion. Your answers will be kept confined to a space with multiple layers of security protection. Additionally, your information will be destroyed within five years after completion of the study.

Please be aware that the researcher has no affiliation with your employer, thus your answers will not be provided to the agency. Again, to maintain as much anonymity, refrain from completing the survey at your agency.

Aside from feelings of ambiguity and emotions brought upon reflecting on work-related experiences, there are no perceived additional risks associated with participating in the study.

By giving consent, you acknowledge that you meet the requirements to participate in the study (e.g., over 18 years old and identify as a mental health counselor), have an understanding of the nature and procedures of the study, and that you are aware of your responsibilities and the risks and benefits associated with your participation. If you have

any questions or concerns, wish to obtain results of the study, or if you need to seek mental health services, please contact the researcher.

If you would like to participate in the study, please proceed with answering the following questionnaires. After completion of the survey, please close, seal, and place the pre-addressed survey packet in the mail.

If you do not wish to participate, please close, seal, and place the pre-addressed survey packet in the mail.

Thank you for your time and participation.

Researcher: Sultan Magruder, M.S.
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Appendix F

Email Alert

Dear Colleagues,

We would like to alert you of an interesting new counseling study that you may have an opportunity to participate in. The counseling study conducted by Sultan Magruder, M.S., Doctoral Candidate, from the counseling psychology program at Oklahoma State University will explore the role of self-care in mental health outcomes by surveying mental health counselors employed at **(insert name of agency)**.

Participation in this project will be beneficial for the knowledge to be gained in improving the health and well-being of mental health counselors.

You may receive a packet in your workplace mailbox in the few days. Please take time to fill out the survey materials and return it to Sultan in the enclosed stamped envelope.

Thank you in advance.

Sincerely,

(Insert name of administrator and title)

VITA

Sultan Aquil Nafis Magruder

Candidate for the Degree of

Doctor of Philosophy

Thesis: BURNOUT, EMPATHY, AND SELF-CARE AMONG MENTAL HEALTH COUNSELORS

Major Field: Educational Psychology

Biographical:

Education:

Completed the requirements for the Doctor of Philosophy in Educational Psychology at Oklahoma State University, Stillwater, Oklahoma in July, 2017.

Completed the requirements for the Master of Science in your Educational Psychology at Oklahoma State University, Stillwater, Oklahoma, in 2013.

Completed the requirements for the Bachelor of Arts in Psychology at Indiana University of Pennsylvania, Indiana, Pennsylvania in 2012.

Experience:

Completed the Requirements of a Doctoral Internship at the Pennsylvania State University Counseling and Psychological Services

Professional Memberships:

Ronald E. McNair Scholar, 2011-present

The Association of Black Psychologists Adjunct Member

Student member of Psi Chi, The National Honor Society in Psychology

American Psychological Association, Graduate Student Affiliate